PUBLIC HEARING

BY

JOINT LEGISLATIVE STUDY COMMITTEE ON AGING

Columbia, September 20, 1984

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Senator Hyman Rubin, Chairman

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Transcription prepared by: Mrs. Rose Mary S. Smith, Adm. Asst.
Senate Medical Affairs Committee

The Annual Public Hearing of the Joint Legislative Study Committee on Aging was held in the Blatt House Office Building, Room 101/109, in Columbia, South Carolina, on Thursday, September 20, 1984. The Hearing convened at 10:30 A.M.

Senator Hyman Rubin, Chairman of the Committee, called the Hearing to order. In his opening remarks, Senator Rubin said that the Committee has worked diligently combining the staffs of the Committee and Medical Affairs. Although we can never accomplish all we want to, he feels that last year was another productive year. He briefly referred to some of the accomplishments:

-The Community Long Term Care Program has gone statewide and seems to be well accepted.

-By providing 14 cents per mile tax allowance a boost was given to those engaged in volunteer work.

-Legislation was passed relating to Adults in Life-Threatening Situations which greatly improved the capacity of law enforcement people to deal with persons in such situations.

-An additional 2 percent cost-of-living increase for state retirees was achieved which represented some 2.5 million dollars.

-Homestead exemptions went from $15,000 of fair market value to $20,000 and while this is not enough, it still costs the State for every $1,000 of value 1 million dollars. With the additional $5,000 added, the State is now appropriating over 20 million dollars for that program.

-There was some concern concerning the possibility of taxing social security benefits, but that was avoided by appropriate legislation.

-Additional legislation was passed to help state auditors with respect to some confusion concerning the agricultural use of property which was a very complicated issue.

"We work as hard as we can for the benefit, dignity and improvement of life of our senior citizens," said Senator Rubin.

At this time the members of the Committee and staff were introduced: Representatives Waldrop and Blackwell, Mrs. Keller H. Barron, Director of Research and Administration, Representative Pat Harris, Vice Chairman of the Committee, Dr. Carlysle Holler, Gubernatorial Appointee, and Dr. Julian Parrish, Gubernatorial Appointee, and Rose Mary Smith, Administrative Assistant for the Senate Medical Affairs Committee. "We are able to do our work at a minimum budget for the Committee on Aging because I have the privilege of being the Chairman of the Medical Affairs Standing Committee and we pool our people and our resources to get the job done."

He welcomed Channel 7 of Spartanburg and Mrs. Serena Staggers, representing the Acting President of Benedict College, Mrs. Betty S. Shearin, and Mrs. Alice Moore with students from Allen University.

With these preliminary remarks, he called the first speaker.

M. L. Meadors, Jr., Chairman
S. C. Commission on Aging
Columbia, SC

Since his appearance before the Committee last year, Reverend Meadors is pleased to say that many positive things have been done in the field of aging and much of the credit must go to the dedicated staff of the Commission on Aging as well as to the Study Committee on Aging.

The Commission recently approved funding for three new senior centers in the State--Georgetown, Abbeville and Winnsboro. The Governor's Resource Panel on the Elderly has recommended that there be such a center in every county in the State. This has long been a goal of the Commission. There are already 39 multipurpose senior centers in the State which serve as focal points in a community for the elderly.

The Governor's Resource Panel on the Elderly has presented its recommendations to help prepare us for an increasing older population. Almost every state agency as well as the private sector will be involved in carrying out these recommendations. Fifty-four have been assigned to the Commission on Aging some of which the Commission is already doing; however, a lot more needs to be done. There are now more than 460,000 South Carolinians who are 60 or older, most of them are healthy, but there are also many who are frail, isolated or poor. Some are financially secure but are living in fear of the day when they can no longer take care of themselves or their homes.

More than 2 million meals were served at 158 nutrition sites this past year and 474,000 meals were delivered to homes. In addition other services, such as homemakers, transportation and reassurance visits and telephone calls were made to 82,000 elderly.

But more help is needed--especially to pass the Community Services Bill which will enable the frail elderly to stay in their homes and communities as long as possible. A uniform, statewide discount card program for the elderly needs to be established and older workers need to be given assurance of fair treatment and continuing opportunities.

Senator Rubin expressed his appreciation for the outline of this very positive program.

SENATOR RUBIN AND MEMBERS OF THE COMMITTEE. I APPRECIATE THIS OPPORTUNITY TO COME BEFORE YOU TODAY.

I AM PLEASED TO BE ABLE TO SAY THAT SINCE I STOOD HERE BEFORE YOU LAST YEAR, MANY POSITIVE THINGS HAVE OCCURED IN THE FIELD OF AGING IN SOUTH CAROLINA; MUCH OF THE CREDIT MUST BE GIVEN TO THE DEDICATED STAFF OF THE COMMISSION ON AGING. UNDER THE LEADERSHIP OF HARRY BRYAN, THEY HAVE CONTINUED TO IMPROVE AND INCREASE SERVICES TO OLDER SOUTH CAROLINIANS. THEY HAVE COORDINATED THE WORK OF THE STATE-WIDE AGING NETWORK AND INITIATED JOINT EFFORTS WITH OTHER AGENCIES AND ORGANIZATIONS TO PROVIDE FOR THE ELDERLY WHO ARE IN NEED, KEEP OLDER PEOPLE IN THE MAINSTREAM OF OUR SOCIETY, AND ADVOCATE FOR CHANGES THAT WILL MAKE THE FUTURE BETTER FOR ALL OF US AS WE GROW OLDER.

MUCH OF THE CREDIT MUST BE GIVEN TO THIS COMMITTEE, WHICH HAS WORKED DILIGENTLY TO ENACT LEGISLATION BENEFICIAL TO THE ELDERLY AND PREVENT LEGISLATION THAT DISCRIMINATES AGAINST THEM.

JUST RECENTLY, THE COMMISSION APPROVED FUNDING FOR THREE NEW SENIOR CENTERS IN THE STATE - IN GEORGETOWN, ABBEVILLE, AND WINNSBORO. THERE ARE ALREADY 39 MULTIPURPOSE SENIOR CENTERS IN SOUTH CAROLINA, SERVING AS FOCAL POINTS IN COMMUNITIES - PLACES WHERE OLDER PEOPLE GET TOGETHER FOR NUTRITIOUS MEALS, COMPANIONSHIP, ENTERTAINMENT, AND EDUCATIONAL PROGRAMS. WE NEED SUCH A PLACE IN EVERY COMMUNITY. OLDER PEOPLE NO LONGER BELIEVE THAT RETIREMENT FROM AN OCCUPATION IS SYNONOMOUS WITH WITHDRAWAL FROM AN ACTIVE, PRODUCTIVE PURSUIT OF NEW RELATIONSHIPS AND EXPERIENCES.

AS YOU KNOW, THE GOVERNOR'S RESOURCE PANEL ON THE ELDERLY HAS PRESENTED ITS RECOMMENDATIONS TO PREPARE OUR SOCIETY FOR A RAPIDLY INCREASING OLDER POPULATION. VIRTUALLY EVERY STATE AGENCY AND THE PRIVATE SECTOR WILL BE INVOLVED IN IMPLEMENTING THOSE RECOMMENDATIONS, BUT 54 OF THEM HAVE BEEN ASSIGNED TO THE SOUTH CAROLINA COMMISSION ON AGING. FORTUNATELY, WE ARE ALREADY DOING SOME OF THE TASKS THAT MUST BE DONE, BUT AT TIMES I FEEL THAT WE ARE ABLE TO DEAL WITH ONLY THE TIP OF THE ICEBERG. WE ESTIMATE THAT THERE ARE MORE THAN 460,000 SOUTH CAROLINA CITIZENS WHO ARE 60 OR OLDER. MOST OF THEM ARE HEALTHY, ACTIVE PEOPLE, BUT THERE ARE ALSO MANY WHO ARE FRAIL, ISOLATED, OR POOR - OR ALL OF THESE COMBINED. SOME HAVE A WEALTH OF TALENT AND EXPERIENCE THAT IS GOING TO WASTE BECAUSE OF SOCIETY'S ATTITUDE TOWARD AGING; SOME ARE FINANCIALLY SECURE BUT LIVING IN DREED OF THE TIME WHEN THEY CAN NO LONGER TOTALLY CARE FOR THEMSELVES OR THEIR HOMES.

EVEN THOUGH THE NUMBERS WILL SOUND ENCOURAGING, WE NEED YOUR SUPPORT NOW MORE THAN EVER BEFORE. MORE THAN TWO MILLION MEALS WERE SERVED AT 158 NUTRITION SITES THIS PAST YEAR; 474,000 MEALS WERE DELIVERED TO THE HOMEBOUND. MORE THAN 82,000 OLDER PEOPLE RECEIVED OTHER SERVICES, SUCH AS HOMEMAKERS, TRANSPORTATION, AND REASSURANCE THROUGH VISITS OR TELEPHONE CALLS.

THAT SOUNDS GOOD, BUT WHEN WE SEE WHAT HEALTH CARE COSTS ARE DOING TO THE ELDERLY - WHEN WE HEAR THAT MEDICARE AND MEDICAID ARE DETERIORATING, WE REALIZE THAT WE MUST WORK HARDER THAN EVER BEFORE. WE NEED YOUR HELP TO PASS THE COMMUNITY SERVICES BILL THAT WILL ENABLE THE FRAIL ELDERLY TO STAY IN THEIR HOMES AND COMMUNITIES FOR AS LONG AS POSSIBLE. IN TERMS OF BOTH QUALITY OF LIFE AND COST

OF CARE, IN HOME SERVICES ARE A NECESSITY. WE MUST ALSO WORK CLOSELY WITH THE AMERICAN ASSOCIATION OF RETIRED PERSONS AND THE SOUTH CAROLINA FEDERATION OF OLDER AMERICANS TO CURB THE COST OF HEALTH CARE FOR ALL OF US; THIS IS THE NUMBER ONE CONCERN OF MANY OLDER PEOPLE.

OTHER CHALLENGES THAT WE FACE INCLUDE MAKING OUR AGING NETWORK AND SERVICES MORE VISIBLE, CHANGING THE PREVAILING NEGATIVE ATTITUDE TOWARD AGING AND THE ELDERLY TO A MORE POSITIVE ONE, ESTABLISHING A UNIFORM, STATEWIDE DISCOUNT CARD PROGRAM FOR THE ELDERLY, AND ASSURING OLDER WORKERS OF FAIR TREATMENT AND CONTINUING OPPORTUNITIES.

WE ASK FOR YOUR CONTINUING SUPPORT; WE REALIZE THAT WE CANNOT ACCOMPLISH THE TASKS SET BEFORE US BY THE GOVERNOR'S RESOURCE PANEL ON THE ELDERLY AND MEET THE CHALLENGES I HAVE MENTIONED WITHOUT IT.

Harry Bryan, Director
S. C. Commission on Aging
Columbia, SC

Mr. Bryan added his thanks for the Committee's continuing effective work in the General Assembly in behalf of the State's older citizens.

He asked as he has done for the past two years that the Committee introduce and support the Bill known as the Community Services for Older Persons Act which is their major recommendation and request to the Committee this year. They are asking the Budget and Control Board to approve funding for this proposed program in the General Appropriation Bill. The funds will be used for direct services; such as, homemakers, personal care, adult day care, respite, health maintenance, home-delivered meals, chore, and medical transportation for those elderly who are most apt to suffer from health-impairments and who are most likely to require institutionalization, those 75+ and 85+.

He emphasized that the Program would not duplicate the Long Term Care Program as there are two very important differences; i.e., (1)it would not be limited to low income Medicaid eligible persons and thereby reach people not covered by LTC, and (2) clients would not have to be certified as needing nursing home care. All persons in this Program would be required to pay in accordance with a sliding fee scale, based on their ability to pay. Funds collected would be used to add more services. The Commission on Aging will distribute these funds statewide through its Area Agencies on Aging, in accordance with the Commission's formula for the distribution of Federal Older Americans Act funds. (This funding formula is now being reviewed by a Task Force appointed by Reverend Meadors.) Area Agencies on Aging would publish RFP's and contract with provider agencies to delivery the most needed services at the local level. Attached to Mr. Bryan's statement is a list which summarizes the projected use of the 2.5 million dollars requested for community services for the frail elderly

Mr. Bryan expressed his support for the program which Mr. Bill James, the new Director of the Commission for the Blind, will present. He pledged his support to help more elderly blind persons and assured the Committee that they will support any actions the Committee will undertake for health care cost containment.

Rep. Waldrop moved to have the bill sponsored by House and Senate Members of this Committee, reintroduced and prefiled by next session.

Senator Rubin asked for voice votes on this motion; it was unanimously adopted.

Rep. Harris proposed to have copies of the bill made available to all members of the Committee.

Senator Rubin explained the absence of Senators Doar and McLeod who both have conflicts, as well as Gubernatorial Appointee Mrs. Gloria Sholin who recently sustained an accident

SOUTH CAROLINA COMMISSION ON AGING

PRESENTATION TO GENERAL ASSEMBLY'S STUDY COMMITTEE ON AGING
9/20/84

HARRY R. BRYAN, DIRECTOR

MEMBERS OF THE LEGISLATIVE STUDY COMMITTEE ON AGING, I WANT TO ADD MY THANKS TO THOSE EXPRESSED BY OUR CHAIRMAN, MR. MEADORS, FOR YOUR CONTINUING EFFECTIVE WORK IN THE GENERAL ASSEMBLY ON BEHALF OF SOUTH CAROLINA'S OLDER CITIZENS, AND ALSO THANK YOU FOR HOLDING THIS PUBLIC HEARING ANNUALLY AND GIVING ALL OF US AN OPPORTUNITY TO PRESENT OUR THOUGHTS AND RECOMMENDATIONS TO YOU.

AS WE HAVE FOR THE PAST TWO YEARS, WE AGAIN WANT TO URGE YOU TO INTRODUCE AND SUPPORT A BILL WHICH HAS BECOME KNOWN AS "THE COMMUNITY SERVICES FOR OLDER PERSONS ACT".

THIS BILL WAS INTRODUCED BY YOUR HOUSE MEMBERS, MR. HARRIS, MR. BLACKWELL, AND MR. WALDROP IN 1983 AND AMENDED IN 1984. AS THE BILL REQUESTS $2.5 MILLION FOR COMMUNITY IN-HOME SERVICES FOR THE HEALTH-IMPAIRED ELDERLY, IT WAS REFERRED TO THE WAYS AND MEANS COMMITTEE. DUE TO THE ATTENTION DEVOTED TO EDUCATION AND THE INCREASE IN THE SALES TAX, THE WAYS AND MEANS COMMITTEE DID NOT CONSIDER THIS BILL UNTIL LATE IN THE SESSION, AFTER THE APPROPRIATIONS BILL HAD BEEN SENT TO THE SENATE AND THE SENATE FINANCE COMMITTEE.

HOWEVER, THERE WAS CONSIDERABLE SUPPORT FOR THE LEGISLATION IN THE WAYS AND MEANS COMMITTEE. MEMBERS OF THAT COMMITTEE DRAFTED A RESOLUTION IN SUPPORT OF THE PROGRAM CALLED FOR IN THE BILL, PASSED IT, AND WERE SUCCESSFUL IN GETTING THE FULL HOUSE TO ALSO ENDORSE THE RESOLUTION, WHICH ASKED THE SENATE

FINANCE COMMITTEE TO APPROPRIATE THE FUNDS TO IMPLEMENT THIS PROGRAM.

HOWEVER, THE HOUSE RESOLUTION WAS RECEIVED BY THE SENATE FINANCE COMMITTEE TOO LATE TO GIVE FULL CONSIDERATION TO THE BILL. WE ARE OPTIMISTIC THAT THE HOUSE WILL PASS IT THIS YEAR AND THAT THE SENATE WILL ALSO CONSIDER IT AND SUPPORT IT.

I SHOULD POINT OUT TO YOU THAT THIS YEAR, FOR THE FIRST TIME, WE ARE ASKING THE BUDGET & CONTROL BOARD TO APPROVE FUNDING FOR THIS PROPOSED PROGRAM IN THE GENERAL APPROPRIATIONS BILL.

LET ME BRIEFLY REMIND YOU OF THE NEED FOR THIS LEGISLATION AND THE HIGHLIGHTS OF THE BILL. I DO NOT HAVE TO CITE STATISTICS TO THIS PANEL ON THE RAPID GROWTH OF SOUTH CAROLINA'S OLDER POPULATION, THOSE 75+ AND 85+, THE ELDERLY WHO ARE MOST APT TO SUFFER FROM HEALTH-IMPAIRMENTS WHICH PUT THEM AT RISK AND WHO ARE MOST LIKELY TO REQUIRE INSTITUTIONALIZATION IF COMMUNITY, IN-HOME SERVICES ARE LACKING. YOU HAVE HEARD THE STATISTICS BEFORE. IT IS FOR THIS GROUP THAT THIS LEGISLATION IS DESIGNED.

THE FUNDS WILL BE USED FOR DIRECT SERVICES SUCH AS HOMEMAKER, PERSONAL CARE, ADULT DAY CARE, RESPITE, HEALTH MAINTENANCE, HOME-DELIVERED MEALS, CHORE, AND MEDICAL TRANSPORTATION.

THIS PROGRAM WOULD COMPLEMENT, NOT DUPLICATE, THE STATE LONG TERM CARE PROGRAM. IT HAS TWO VERY IMPORTANT DIFFERENCES FROM THAT PROGRAM. FIRST, IT WOULD NOT BE LIMITED TO LOW INCOME MEDICAID ELIGIBLE PERSONS, SO IT WOULD REACH PEOPLE NOT COVERED BY THE LONG TERM CARE PROGRAM. SECOND, CLIENTS WOULD NOT HAVE TO BE CERTIFIED AS NEEDING NURSING-HOME CARE, IN ORDER TO RECEIVE SERVICES UNDER THIS PROPOSED PROGRAM. BY REACHING PEOPLE EARLIER, WE WANT TO PREVENT THEIR FURTHER DETERIORATION.

MOST OF THE CLIENTS IN THIS PROGRAM COULD PAY SOME OF THE COST OF THE SERVICES; A FEW COULD PAY THE ENTIRE COST. ALL WHO RECEIVE SERVICES IN THIS PROGRAM WE ARE REQUESTING WOULD BE REQUIRED TO PAY WHAT THEY CAN TOWARDS THE COST OF THE SERVICES THEY RECEIVE, IN ACCORDANCE WITH A SLIDING FEE SCALE, BASED ON THEIR ABILITY TO PAY. FUNDS COLLECTED WOULD BE USED TO ADD MORE SERVICES.

THE PROPOSED LEGISLATION CALLS FOR THE COMMISSION ON AGING TO DISTRIBUTE THESE FUNDS STATEWIDE, THROUGH OUR AREA AGENCIES ON AGING, IN ACCORDANCE WITH THE COMMISSION'S FORMULA FOR THE DISTRIBUTION OF FEDERAL OLDER AMERICANS ACT FUNDS. THE AREA AGENCIES ON AGING WOULD PUBLISH "REQUESTS FOR PROPOSALS" (RFP'S) AND CONTRACT WITH PROVIDER AGENCIES TO DELIVER THE MOST NEEDED SERVICES AT THE LOCAL LEVEL.

BY THE WAY, I WOULD LIKE TO LET YOU KNOW AS A POINT OF INTEREST THAT OUR FUNDING FORMULA IS NOW BEING REVIEWED BY A TASK FORCE APPOINTED BY MR. MEADORS, IN CASE YOU RECEIVE SOME QUESTIONS ABOUT THAT. YOUR VERY CAPABLE RESEARCH AND ADMINISTRATIVE DIRECTOR, MRS. KELLER BUMGARNDER-BARRON, IS ON THAT TASK FORCE, ALONG WITH MR. RUDY LONG OF THE GOVERNOR'S OFFICE; DR. GEORGE FULTON, PRESIDENT OF THE SOUTH CAROLINA FEDERATION OF OLDER AMERICANS; TWO MEMBERS OF OUR COMMISSION, AND SEVERAL OTHERS.

THIS COMMUNITY SERVICES LEGISLATION TO PROVIDE IN-HOME SERVICES FOR THE FRAIL, VULNERABLE ELDERLY IS OUR MAJOR RECOMMENDATION AND REQUEST TO YOU THIS YEAR. USING STATISTICS FROM THE COMMUNITY LONG TERM CARE PROJECT AND INFORMATION FROM NATIONAL STUDIES, APPLIED TO SOUTH CAROLINA'S OLDER POPULATION, WE HAVE CONSERVATIVELY ESTIMATED THAT 2,881 OF OUR

STATE'S ELDERLY NEED PERSONAL CARE AT HOME BUT EITHER HAVE INCOMES ABOVE THE MEDICAID CAP OR DO NOT NEED INTERMEDIATE NURSING CARE, AND THAT IT WOULD COST $2,545,264 TO PROVIDE THIS CARE TO THEM. WE HAVE ATTACHED ONE SHEET WHICH SUMMARIZES THE USE OF $2.5 MILLION IF IT WERE USED EQUALLY FOR HOME-DELIVERED MEALS, HOMEMAKER SERVICES, AND ADULT DAY CARE.

MR. MEADORS HAS MENTIONED THAT WE ARE WORKING ON A STATEWIDE IDENTIFICATION/DISCOUNT CARD FOR SENIORS, AS RECOMMENDED BY THE GOVERNOR'S RESOURCE PANEL ON THE ELDERLY--NOT THROUGH LEGISLATION, BUT BY EXECUTIVE ORDER.

I WANT TO EXPRESS OUR SUPPORT FOR THE PROGRAM WHICH MR. BILL JAMES, THE DIRECTOR OF THE COMMISSION FOR THE BLIND, WILL PRESENT TO YOU THIS AFTERNOON. WE ARE ENTHUSIASTIC ABOUT WORKING WITH THE COMMISSION FOR THE BLIND TO HELP MORE ELDERLY BLIND PERSONS, AND I THINK YOU TOO WILL BE PLEASED WITH HIS IDEAS AND PLANS.

WE WILL STRONGLY SUPPORT ANY ACTIONS YOU MIGHT UNDERTAKE FOR HEALTH CARE COST CONTAINMENT, AND I KNOW THAT WE WILL ALSO WANT TO SUPPORT SOME OF THE OTHER RECOMMENDATIONS TO BE MADE TO YOU TODAY, SUCH AS THOSE TO BE PRESENTED BY THE STATE OMBUDSMAN, BILL BRADLEY.

THANK YOU AGAIN FOR ALL YOU ARE DOING FOR SOUTH CAROLINA'S OLDER CITIZENS AND FOR THIS OPPORTUNITY TO APPEAR BEFORE YOU TODAY.

SOUTH CAROLINA COMMISSION ON AGING

PROJECTED USE OF $2.5 MILLION
FOR COMMUNITY SERVICES FOR
THE FRAIL ELDERLY*

HOME-DELIVERED MEALS

	Total Cost	Unit Cost	Total Meals	Meal/Day
Current Funding Level	$1,986,947	$3.39	586,120	2,345
Funds Requested	833,334		245,821	983
Fees Projected	166,667		49,164	196
	$2,986,948	$3.39	881,105	3,524

As a result of turnover during the year, approximately 1.5 individuals are served for each meal per day. State Funds, together with fees collected (estimated at 20% of cost), would therefore provide an additional 1,179 meals per day to 1,768 frail older persons.

HOMEMAKER SERVICE

	Total Cost	Unit Cost	Total Hours	Hours/Week
Current Funding Level	$1,071,880	$7.65	140,115	2,695
Funds Requested	833,333		108,932	2,095
Fees Projected	166,666		21,786	419
	$2,071,879	$7.65	270,834	5,209

Individuals receive approximately four (4) hours of service per week; funds projected would provide an additional 2,514 hours per week of service for 629 older individuals.

ADULT DAY CARE

	Total Cost	Unit Cost	Total Hours	Hours/Day
Current Funding Level	$ 140,918	$2.14	65,850	263
Funds Requested	833,333		389,408	1,557
Fees Projected	166,666		77,881	311
	$1,140,917	$2.14	533,139	2,131

Adult Day Care Centers usually provide four (4) hours of care each day. The projected increase of 1,868 hours would serve an additional 467 older persons.

*Funds requested were equally distributed over the three (3) services currently being provided most frequently to frail older persons now being served by the Aging Network in South Carolina. Actual distribution of funds by service may vary as a result of local needs.

Ms. Abby Fowler, R.D., M.S., President-Elect
S. C. Dietetic Association
205 Crestline Dr.
Spartanburg, SC 29301

The Association provides direction and leadership for good dietetic practice and promotes optimal health and nutritional status of the population. Again, we heard the statistics that by 1990 almost 13 percent of the American population will be over 65 and that the fastest growth will be in the over 75 age group. The Association's challenge is to help increase the chances of maintaining optimum health during this lengthened life span.

As a dietary consultant to nursing homes, Ms. Fowler has seen firsthand that many patients who were admitted to a health care facility suffered primarily from malnutrition. Within just a few days or weeks of optimal nutritional intake a dramatic difference in the physical and mental functioning of such patients could be seen. However, she calls this "an expensive way to approach the problem." While the congregate and home-delivered meal program is helping to reduce admission to such institutions, it could be even more effective in reducing health care costs if clients in need of therapeutically modified diets and nutritional counseling would have access to a qualified, registered dietitian. Despite the fact that nutrition plays an active part in the treatment of four of the most prevalent chronic conditions of the elderly--cardiovascular disease, cancer, hypertension and diabetes--third party reimbursement is not generally available for nutritional assessment and counseling.

The following recommendations were made to the Committee:

1. Make the congregate and home-delivered meal program more effective by providing therapeutically modified meals and nutritional counseling by a registered dietitian.

2. Retain separate funding for nutrition services and supportive services. Provide meals to the homebound during weekends when the need is severe.

3. Make nutritional assessment and dietary counseling services more widely available by advocating third party reimbursement for these cost-effective measures.

4. Good nutrition is the keystone of good health for persons of any age--for the elderly the need is crucial.

South Carolina Dietetic Association

ORAL STATEMENT -- Sept. 20, 1984
PUBLIC HEARING
STUDY COMMITTEE ON AGING

Mr. Chairman and members of this committee, I am Abby Fowler and I am making this statement on behalf of the South Carolina Dietetic Association which is an association of over 275 registered dietitians.

The stated purpose of our organization is to provide direction and leadership for quality dietetic practice, education and research and to promote optimal health and nutritional status of the population. It is evident that the goals of my association and this committee are similar in that each is striving to provide the services that will keep older individuals healthy, independent and active in their communities.

By 1990, almost 13% of the American population will be over 65. The very fastest growth is occurring in the over 75 age group. Our challenge is to provide guidelines to increase the chances of maintaining optimum health during this lengthened life span.

As a former hospital clinical dietitian and a current dietary consultant to nursing homes, I have seen many patients who were sick and admitted to a health care facility primarily because they were malnourished. Often, a few days or weeks of optimal nutritional intake in such institutions makes a dramatic difference in the physical and mental functioning of such individuals. But, this is an expensive way to approach the problem.

South Carolina Dietetic Association

In South Carolina, the congregate and home delivered meals program funded by the Older Americans Act is helping to reduce admissions to such institutions. At least 9000 individuals over 60 are served by this program. It could be even more effective in reducing health care costs if clients who need therapeutically modified diets and nutritional counseling could have these needs met by a qualified, registered dietitian who might be the nutrition project director, or on staff part-time.

The need for nutrition education and counseling is vital to our older citizens who need to use their limited funds wisely in making food choices. Separating dietary facts from fiction is not easy, and the elderly may be especially vulnerable to misinformation.

Despite the fact that nutrition plays an active part in the treatment of four of the most prevalent chronic conditions of the elderly--cardiovascular disease, cancer, hypertension, and diabetes--third party reimbursement is not generally available for nutritional assessment and counseling.

Our recommendations to this committee are these:

1) Continue support of congregate and home delivered meals for the elderly. Make this program even more effective by providing therapeutically modified meals and nutritional counseling and education by a qualified, registered dietitian.

2) Retain separate funding for nutrition services and supportive services so that the funding for meals will not be diminished in competition with other needs. It is my understanding that the law allows a transfer of funds out of the nutrition program into other services and that this is being done in South Carolina. We recommend this be discontinued and that those nutrition funds be retained in the nutrition program to provide meals to the homebound during weekends when the need is severe, and to provide meals to a greater number of the elderly in this state.

3) Support efforts to make nutritional assessment and dietary counseling services more widely available to older South Carolinians by advocating third party reimbursement for these cost-effective measures.

4) Realize that good nutrition is truly the keystone of good health for those of any age--for the elderly, the need is crucial.

Thank you for this opportunity to appear before you today.

Ruby Fowler, RD, RN, MS
Pres. Elect 1984-85
S.C.D.A.

Dr. Cynthia M. Gordon, R.D.
Nutritional Consultant
S. C. Dietetic Association
114 Buckingham Rd.
Easley, SC 29640

Dr. Gordon supported the recommendations outlined by Ms. Fowler.

Research indicates that 86 percent of all elderly persons suffer from at least one chronic disease. The medication to treat one of these diseases often increase nutritional requirements above and beyond what the Recommended Dietary Allowance is for a healthy elderly person. Established feeding programs usually attempt to offer one-third of the RDA in a single meal, but those with a chronic disease not only require nourishment, but are in great need of nutritional assessment and counseling to (1) make them aware of their special need, and (2) educate them to meet this need.

Dr. Gordon cited an example of an 82-year old Medicaid patient who was literally starving when she was admitted to a long-term care facility and who after receiving a regular diet made a strong recovery. While food is a basic biological need, nutrition is more critical as people advance in age.

Funding for nutritional programs is cost-effective in many areas, for example, it (a) decreases the need for drugs, (b) decreases the number and length of hospitalizations, and (c) contributes to general health so that elderly can stay in their own homes and remain independent, which in turn delays the need for nursing home care.

Dr. Parrish referred to the 275 registered dietitians and wondered what the capabilities were of distributing information to the existing population.

Dr. Gordon said if it were done in terms of group care it does not take much of a dietitian's time to be a consultant with a congregate meal program tor home-delivered meals to assure that these meals are meeting the one-third of the recommended dietary allowances. Individual counseling, of course, would take longer. There are dietitians employed in hospitals, nursing homes and in private practice.

CYNTHIA M. GORDON, PH.D., R.D.
Nutritional Consultant

114 Buckingham Rd. • Easley, S.C. 29640 • 859-0865

September 20, 1984

Statement for the S.C. Study Committee on Aging
Presented by Dr. Cynthia M. Gordon of the S.C. Dietetic Assn.

Thank you for the opportunity to address the subject of nutritional needs of elderly South Carolinians! I am most anxious to impress upon you the importance of the recommendations outlined by Ms. Fowler. These recommendations are valid and will be cost-effective in every sense of the term.

Allocation of funds in the state should reflect needs assessment of our elderly. Nutrition-related funding can affect all aspects of life (psychological, social and physical); thus meet a broad spectrum of needs to enhance the quality of life for our elderly population.

Nutritional status at any age is a reflection of previous and present dietary state. Inadequate nutrition translates into accelerated deterioration of physical and functional characteristics. As nutritional status declines, physical capabilities decrease accordingly and food intake becomes even less. There is a vicious cycle of declining physical capabilities and decreased ability to care for oneself. In other words, physiological changes cause our elderly to make relatively unconscious changes in diet. They become apathetic about food, have difficulty shopping and preparing food for themselves, select easy-to-prepare foods generally high in carbohydrate; and are faced with a narrow diet selection

which causes further health problems.

Research indicates that 86% of all elderly persons suffer from at least 1 chronic disease. These disease processes and the medications required to treat them often increase nutritional requirements above and beyond that which the Recommended Dietary Allowance is for a healthy elderly person. While established feeding programs generally attempt to offer 1/3 of the RDA in a single meal, those with chronic diseases not only require nourishment, but are in desparate need of nutritional assessment and counselling to: 1) make them aware of their special needs, and 2) educate them as to the most effective means of meeting their needs.

As a consulting dietitian for long-term care facilities, I continually assess newly admitted residents who are weak and nutritionally depleted. Aside from nutrition problems relating to chronic diseases, gross malnutrition is evident and is the primary diagnosis for some. A case in point is a S.C. resident who I shall refer to as Miss Georgie. Miss Georgie is an 82-year old black female admitted to a facility in August of 1983. She is a Medicaid patient who had received no assistance from any feeding program. On admission her weight was 79½ pounds, her hair could be easily plucked, she was unsteady on her feet and had to be lifted to be moved, she was disoriented in 3 spheres and she could not complete sentences to adequately communicate her needs. Now 1 year later, her weight is 105½ pounds (a 26 # gain), hair is healthy, she can walk with minimal assistance, she is well-oriented and can communicate well. She has received a regular diet.

Malnutrition and hunger are realities in South Carolina! This lady had been starving!!! Imagine the difference that early assessment and involvement in a feeding program could have made to her!

What does a person die of who dies of malnutrition? Death certificates seldom read "malnutrition," but rather identify cause of death as "heart failure" or "respiratory failure." How many Miss Georgies are there in our state?

Food is a basic biological need!

Nutrition is more critical as people advance in age.

Aside from increasing the general quality of life, funding of nutritional programs reflects cost-effectiveness in many other areas. Proper intake: 1) decreases the need for some drugs, 2) enhances the ability of the body to properly respond to drugs, 3) decreases the number of hospitalizations, 4) decreases the length of hospitalizations, 5) affects outcome of surgery and wound healing, and 6) enhances general health so that elderly can stay in their own homes and remain independent (thus delaying or decreasing the need for nursing home care).

There must not be discrepancies in needs assessments and policies made for dealing with elderly citizens. As others speak today consider how nutritional status may affect each aspect of life under consideration. Nutrition is a primary factor in caring for our elderly population. We advocate planning for it wisely and funding it adequately!

Dr. Hilda K. Ross, Director
Mental Health Services for the Aging
S. C. Department of Mental Health
Columbia, SC 29202

This presentation reviewed the last four annual presentations before the Committee and the steady course of responsiveness by DMH.

The Department is negotiating with the Health and Human Services Finance Commission to prepare reimbursements to provide different levels of care in the boarding homes and community care homes.

Several concerns still exist:

1. Patients continue to be admitted into DMH from general hospitals. This past July and August, of 27 patients admitted directly from hospitals and institutions, 37 percent (10) had major medical problems requiring continuing medical treatment. In the past six weeks, 66 patients from Crafts Farrow were sent directly into Brynes Medical Center for continuing their medical care. All of these patients needed medical care, not psychiatric care--clearly, inappropriate admissions. Half of these patients are ready to leave Byrnes now, but there are no nursing care beds in DMH nor in the community. "Very expensive acute medical beds at Byrnes are being used to provide nursing care."

2. The effect of the moratorium on nursing home beds. For every 1000 people over 65 in this State there are 37 nursing home beds; in Georgia, there are 70 beds for the same number of people over 65. Dr. Ross questioned if DMH is to become a nursing home repository or is the function of the State psychiatric hospitals to treat psychiatric patients.

3. The DMH 1985-86 goal to develop clearly defined psychiatric specialty services in their hospitals should not be diverted into becoming a nursing home industry.

In the area of community services program, DMH has a $500,000 line item in the '85 budget for three elderly services.

1. A pilot program, Elderly Psychiatric Diagnostic Unit, to reach out to the unserved rural elderly.

2. Geriatric Care Team. Services will be provided under the direction of a full-time trained geriatric specialist.

3. Neighborhood Family (NF). Here retraining for everyday living occurs in a home-like setting as opposed to a hospital or clinic. NF attends problems whenever they emerge and thereby assuring an important aspect of prevention and a continuum of services.

In conclusion, Dr. Ross said that South Carolina is developing psycho-social models similar to the NF, but for the young people--there are none for the elderly.

NF works so well and economically with large numbers of the chronically mentally ill elderly that it deserves serious review for funding as a model and should be duplicated throughout the State.

Rep. Harris asked if the planned nursing home beds for Crafts-Farrow will be adequate to take the pressure off the other homes.

Dr. Ross replied that they will not; they are already filled up.

Senator Rubin added that in the General Assembly last year was described as a year of crisis for education, this year the crisis is that of mental health and corrections. "We clearly understand the powerful arguments and facts that you presented."

STUDY COMMITTEE ON AGING
September 20, 1984

Senator Rubin and members of the Study Committee on Aging, once again the S. C. Department of Mental Health welcomes this opportunity to appear before you.

In preparation for today, I reviewed the last four annual presentations before this Committee and found that there has been a steady course of responsiveness by the Department of Mental Health.

- In '80, the SCDMH was dismayed at the commitment process but today the commitment laws are being revised.
- In '81, the speculation about the elderly population explosion and its impact on our hospitals and our Community Mental Health Centers resulted in the years '81/'82 declared a Planning Year to assess the implication of this population increase.
- In '82, the Department looked at the difficult job of relocating selected patients into the community. Subsequently study groups were in place and the mechanism of directing funds to further mental health services in the community were devised.
- In '83, the problem of relocating patients into the community continued to surface. The Department responded by creating a Community Support Program Office with a staff and a budget to oversee the development of community services so that the Community Mental Health Center sector, according to the Mental Health State Plan Advisory Council, "will become and be perceived to be the predominant locus of public mental health services in the State". Training staff is a major component of the CSP Office.

Now it is true that making large scale changes is always slower than the public would like, but then making statewide changes necessarily is slow moving and methodical. For example, we are negotiating with the Health and Human Services Finance Commission to prepare reimbursements to provide different levels of care in the boarding homes and community care homes.

Currently we have several concerns. Patients continue to be admitted into S. C. Department of Mental Health from general hospitals. However, we are watching the DRG's to determine the impact on our admissions, if any, for those patients whose DRG days are used up. For example, this past July and August, of 27 patients admitted directly from hospitals and institutions, 37% (10 people) had major medical problems requiring continuing medical treatment.

In the past 6 weeks, 66 patients from Crafts Farrow were sent directly into Byrnes Medical Center for continuing their medical care: clearly, inappropriate admissions. All of these patients needed medical care, not psychiatric care. Half of them are ready to leave Byrnes now, but neither the Department of Mental Health nor nursing homes in the community have nursing care beds. This means that very expensive acute medical beds at Byrnes are being used to provide nursing care.

Our concern is the effect of the moratorium on nursing home beds. South Carolina has one-half the number of nursing home beds of Georgia. For every 1000 people over 65 in S. C., there are 37 nursing home beds; in Georgia, for every 1000 people over 65, there are 70 beds. Finding beds in S. C. is becoming a real hardship. Our new Dowdy-Gardner Nursing Care Center at State Health Park is already filled; Tucker Center is filled; Crafts Farrow is not only filled but becoming increasingly overcrowded.

We must ask ourselves these questions? Is the SCDMH to become a nursing home repository or is the function of the state psychiatric hospitals to treat psychiatric patients? Can we continue using mental health dollars for nursing care, thereby endangering funds for expanding the community services component? How much is the increase in elderly patients due to the DRG's and/or to the moratorium on nursing home beds in the community? Where are nursing home patients to go?

Our system is filled. The Department of Mental Health 1985-86 goal to develop clearly defined psychiatric specialty services in our hospitals should not be diverted into becoming a nursing home industry. This is the real dilemma for the Department of Mental Health in 1984.

Let us move on to another area, specifically the community services program.

The Department of Mental Health has a $500,000 line item in the '85 budget for three elderly services. The first is a pilot program, ELDERLY PSYCHIATRIC DIAGNOSTIC UNIT to reach out to the unserved rural elderly. It works like this: Rural physicians and/or clinics reach contractual agreements to accept elderly rural clients at a flat fee; then a geriatric trained social worker with medical back-up, completes a battery of assessment tests specific to the elderly. Treatment includes not only mental health services but an assured medical work-up. Community service providers will be involved as components of the Diagnostic Unit.

The second project is the GERIATRIC CARE TEAM. Under the direction of a full-time trained Geriatric Specialist, services will be mobilized for immediate and continuing case management, planning and continuing interventions for elderly clients.

The third project is called the Neighborhood Family (N.F.) "Neighborhood" is used because the participants come from a particular geographic area; the "Family" because the people come together "like a family". It is based on the facts that the mentally ill elderly want to be included as members of a group, want to be appreciated once in a while for tasks completed; and want the opportunity to contribute to others. The chronically mentally ill elderly become captains in planning their services, thereby assuring a rehabilitative and positive approach. This functional approach, one that empowers the members to take positive control in their own behalf, helps them move toward a more rewarding life style. The chronically mentally ill elderly can do this. Our emphasis is shifting from the sickness and treatment model to prevention and rehabilitation.

By allowing the elderly to direct the development of a program, we overcome the wide discrepancy between how the mentally ill elderly regard their continuing ability to function and how others regard them, which is usually as a dysfunctional people. This has serious implications for services and budget allocation.

How does the N.F. work? It is a partnership among equals. There is no hierarchy of staff. Retraining for everyday living occurs in a highly supportive family-like environment, in a home-like setting, that is, in a normal environment as opposed to a hospital or clinic. In a research survey that asked elderly which they would choose, a service or a friendship, they overwhelmingly chose friendship. The N.F. capitalizes on this by fostering peer relationships.

Older people do not experience a medical problem, a psychiatric problem, a social problem in neat categories that occur at specified times. The N.F. attends problems whenever they emerge, thereby assuring an important aspect of prevention. It meets the needs of mentally ill members whose independence is threatened and those members who require increasingly more services, by providing a continuum of services.

Clearly, the Community Mental Health Centers cannot provide all of the required services. Participation by other service providers becomes necessary if the preventive strategies and the constellation of needs are to be met successfully.

IN SUMMARY

South Carolina is developing psycho-social models similar to the N.F. but for the young people; there are none for the elderly. I was amazed to learn that many other states including Maryland, Massachusetts, Florida and Georgia also do not consider the elderly candidates for a program of rehabilitation through socialization and self-devised treatment interventions.

The N.F. works so effectively and economically with large numbers of the chronically mentally ill elderly that it deserves serious review for funding as a model and subsequently for replication throughout the State.

Mrs. Lorraine Bate Orr, Chairman
Society for the Right to Die
139-1/2 Broad Street
Charleston, SC 29401

This presentation dealt with the involvement of Mrs. Orr in the "Right to Die" in South Carolina, which started on April 11, 1983, the day her husband died. Mrs. Orr referred to it not as "after a prolonged illness" but "after a prolonged death." Despite her husband's wishes and his signing of a Living Will long before he became ill, "no one paid the slightest attention to his wishes."

Since the Living Will and The Right To Die are not recognized under South Carolina law, it puts a horrendous burden on the doctors who fear malpractice suits and prosecution. In her opinion the only hope for frightened doctors is to give them legal protection. She informed the Committee that Rep. Keyserling is planning to reintroduce the Living Will Bill next session. She asked the Committee to give Rep. Keyserling support for this legislation.

To Be Given to the Study Committee on Aging

In Columbia, S. C., on September 20, 1984

By Lorraine Bate Orr, Chairman, Society for the Right to Die

Ever since April 11, 1983, I've known that I'd have to do something about the Right to Die in South Carolina. That was the day John, my husband, died, not, as they say, after a prolonged illness, but after a prolonged death. I didn't want to get involved in the Right to Die or the Living Will because I didn't want to nurture my anger or my sorrow. But one day a friend quoted Isaih, Chapter 8, "And the Lord said, 'Whom shall I send and who will go for us?'" Well, the person who's been through it is the obvious one to say, "Okay, I'll go." So now I'm Chairman of the Society for the Right to Die.

Do you remember a TV program called, "Can You Top This?" I doubt if there's anyone in this room who hasn't got a story-topper about a dying friend or relative who was kept alive by artificial means, resuscitators, tubes, machines, anti-biotics, . . . one story worse than the last. We've all seen it, closeup or at a distance, dying people robbed of their humanity, of their <u>right</u> to accept death with dignity. And hasn't each one of us said, "Please don't let it happen to me"?

It happened to us. John had signed the Living Will long ago, addressed to his family, physician, lawyer, and minister and all others whom it may concern. It says, in part: If there is no reasonable expectation of my recovery from extreme physical or mental disability, I direct that I be allowed to die and not be kept alive by medications, artificial means or "heroic measures." No one paid the slightest attention to his wishes. The Living Will and the Right to Die are not

recognized under South Carolina law. This puts a horrendous burden on the doctors--the fear of malpractice suits and fear of prosecution. There are doctors, of course, who will respect the patient's wishes and not extend the process of dying. We weren't that lucky.

Let me tell you about John in the prime of his later years. Most of his lifetime interests carried over into his retirement. He'd been a newspaper reporter, he'd administered a hospital for crippled children, he'd had his own public relations and advertising agency and he'd written poetry all his life. He loved to read and he loved to talk and he had a loving circle of friends. He wrote me a poem once which began, "I am involved with you as the yolk of an egg", and that's just how he felt about the world. I came originally from Canada and John was brought up in New Hampshire. Twenty-eight years ago we were married in New York City and started our broadcasting business, producing and distributing radio and TV public service programs. I was the moderator, John was the director. It was a great life. We interviewed people like Benjamin Spock, Ann Landers, Sidney Sheldon, William Safire, Robert Merrill, Dick van Dyke, Joan Rivers, Uri Geller, Fritz Hollings and Katharine Hepburn, many of whom became our good friends. John could discuss almost any subject with almost anybody he ever met, and sometimes they were pretty hot discussions, as those with Timothy Leary and Sir Oswald Mosley, the British fascist. When we retired we chose Charleston for its beauty, its beaches and its tradition of religious tolerance. (However, we neglected to inquire about recognition of the Right to Die.) John joined the board of the John Ancrum SPCA and he helped increase donations by about 30%. He was elected chairman of the vestry of our church, he went back to creative writing . . . and

suddenly there he was working harder than he every had, but he liked to delude himself that he was loafing. His motto was, "Dolce Far Niente." "It is sweet to do nothing." One day he came home after especially productive meetings and he said, "You know, Lorraine, this is what it's all about: service." At 67 years of age, he had found his answer. Shortly after that, we discovered he had cancer.

An operation that was expected to take four hours took eight. The cancer was extensive. In June, he'd been treated for a sore throat with two rounds of anti-biotics. A biopsy in ~~early~~ August showed cancer of the tonsil. John wasn't operated on until September and the cancer had spread. I think perhaps his life could have been saved, but it wasn't. And then, when he should have been allowed to die, they wouldn't let him.

He never ate solid food again. And he never again spoke clearly. For a long time he communicated by pencil and paper. His speech eventually improved slightly, but I always had to interpret for him and he, who had always enjoyed the subtlty of language, had to restrict himself to words of one or two syllables. I even had to interpret for him to his sons and conversations with his young grandchildren were, of course, out of the question. He never wrote any more, he hardly read and when I read to him, it was only the tried and true, the familiar. He'd enjoyed being good-looking, (and he was!) but half his jaw was gone and even on his daily walk of a couple of hundred feet, kids on their bikes would turn around and come back, pretending not to stare. Of course the beach was over, the slightest wave knocked him down. He suffered a never-ending ghostly pain where his jaw had been. We'd always respected one another's independence and now his was gone.

For the next 22 months, John was in and out of the hospital with various infections and another major operation. I couldn't get any prognosis from the doctors beyond, "Live each day to the fullest." To the fullest? Quality of life is defined by the individual and for John there wasn't any. None. He told our minister he wanted to die; he told me over and over again. Although he was on Hospice, I still could not get a prognosis, until doctors not officially connected with the case told me he had six to eights months. He wanted to be allowed to die but still the anti-biotics kept coming, the very medication he had stated in his Living Will that he did not want. His pain was constant and only morphine seemed to help, that is it did until the doctor cut down the prescription on the grounds that John was becoming addicted. A prostate operation was recommended by the surgeon. When I managed to circumvent it as totally pointless and totally opposed to John's wishes, my motives were called into question.

A few weeks later, John was dead. Medicare and Blue Cross paid the bulk of the bills, so we were lucky . . . I guess. Today as we know, a long-drawn out death like John's could entirely wipe out a family's resources. Last spring, when the Advisory Board of Medicare recommended recognition of the Living Will, it was hoped that this might made a difference in South Carolina, but practically every day someone calls with a new horror story of death being prolonged by heroic means.

I believe that the attitudes of the two doctors attending John are not typical. One of them, I think, is so afraid of a malpractice suit that he feels justified in violating the rights of the patient. And then, there are others, completely without fear, who seem to believe that God gave them omnipotence--the power to determine life or death, or

rather, the power to determine living death.

The only hope for the frightened doctors, it seems to me, is to give them legal protection by passing a Death with Dignity law. I don't know what can be done about the others.

Until this compassionate law is passed, there is always the option of moving to a neighboring state where the Right to Die is recognized: Miss., Fla., Ga., NC., Ala., Va., and La. if we're able to get there, that is . . . and if not, all that's left is the hope that your own doctor will be courageous enough to let you die and merciful enough not to delay death until you become a non-person.

Twice before the Death with Dignity law has been introduced, passing the Senate and dying in Committee, defeated by very narrow margins. I spoke to Representative Harriet Keyserling from Myrtle Beach last week. She is planning to re-introduce the bill. Here is what she said about it, "I believe when you vote on such emotional issues as life and death, it is important to ask: who needs this legislation, who wants it and why?" She goes on to say, "The Death with Dignity bill is permissive legislation needed by those terminally ill patients who want to express, in a legal way, their desire not to have their dying needlessly prolonged by life-sustaining medical treatment. It is needed also by physicians who want to help their patients, but need legal protection from malpractice suits." Representative Keyserling needs your support, in fact, she has to have it.

John suffered a living nightmare. He needn't have. And others need not.

George David Exoo, Minister
Unitarian-Universalist Church
1 Tranquil Drive
Charleston, SC 29407

Reverend Exoo attended the Hearing out of his own conscience, first as a minister and as immediate past president of the Ministerial Association of Charleston.

His basic message is that he believes there is widespread support among the clergy for the type of legislation Mrs. Orr talked about. Since the last time it was introduced, the Vatican through its Sacred Congregation of the Doctrine of Faith has produced a document which has been signed by Pope John Paul endorsing this form of legislation arguing that technological advances now make possible abuses of medicine. "

The Lutherans, the Baptists, the Methodists in South Carolina have come out in favor of this legislation; individual clergymen of almost all denominations--theologically left and right--have done so. Reverend Exoo has been talking with black clergymen in Charleston and they all have agreed with the spirit of this legislation. He will be speaking to the black Ministerial Alliance, the black Baptist Association and has some assurance from the presidents of these organizations it will receive their support.

He urged the Committee to join in support and help Rep. Keyserling get the bill through the legislature.

Senator Rubin stated that when it was up before and twice passed the Senate, it had as much organized support of the churches as anyone can contemplate for any proposed legislation. The fierceness of resistance later on killed it.

Rep. Waldrop said that he is one member of this committee cosponsoring Mrs. Keyserling's bill.

Ms. Nettie Parler, Vice Chair
S. C. Legislative Committee
American Association of Retired Persons
2260 Parlerdale, N. E.
Orangeburg, SC 29115

The State Legislative Committee of this Association has identified the following 1985 legislative objectives:

1. Health care costs containment through hospital budget review and rate setting. In this regard, AARP has launched a nationwide health care campaign.

2. A 4 percent cost-of-living increase in retirement benefits for retired state employees and retired teachers.

3. Enact a revised S. C. Probate Code.

4. Increase Homestead Tax Exemption to $30,000.

The Association further supports the following items:

1. Assure Medicare and Medicaid beneficiaries access to health care services and facilities.

2. Require that automobile insurance companies offer appropriate premium discounts to older persons upon completion of a driver improvement program.

Senator Rubin assured Ms. Parler that the Committee will do their best to implement these objectives.

He recognized Mr. Bill Bradley, State Ombudsman, and Ms. Doris Reeves-Lipscomb, AARP Liaison, from Washington, D.C. The assistance of Mr. and Mrs. Homer Schmitt, who were helping with the registration of speakers, was gratefully acknowledged.

It is an honor and a privilege to present to the Joint Legislative Committee on Aging some of the concerns of members of the South Carolina chapters of the American Association of Retired Persons.

In May, June, and July of this year, the American Association of Retired Persons' membership in South Carolina was surveyed by the State Legislative Committee to help determine the most important legislative concerns of the chapters and units. After reviewing all of the responses submitted by 24 AARP chapters and 18 SCREA (South Carolina Retired Educators Association) units, our State Legislative Committee identified the following 1985 legislative objectives for which we are seeking your support:

Legislative Priorities for 1985

1. Restrain the rise in health care costs in South Carolina through appropriate means including hospital budget review and rate-setting if necessary.

2. Achieve a 4% cost-of-living increase in retirement benefits for retired state employees and retired teachers.

3. Enact a revised South Carolina Probate Code, establishing a process for probating estates with savings of time and costs.

4. Increase the homestead exemption to $30,000 for elderly homeowners.

Support Items for 1985

1. Assure Medicare and Medicaid beneficiaries access to health care services and facilities without discrimination.

2. Require companies offering automobile insurance to offer appropriate premium discounts to older persons completing a driver improvement program approved by the state transportation/safety department.

I shall elaborate on Items 2,3, and 4; and then I shall return to Item 1.

In view of the current rate of general inflation, the request for a 4% cost-of-living increase in retirement benefits for retired state employees and retired teachers is considered to be a fair and modest one. The need is obvious; therefore, I shall not belabor that point. Therefore, to help retired persons cope with inflation losses in 1985, we maintain that a 4% cost-of-living increase in retirement benefits is imperative.

For several years, AARP chapters and SCREA units have advocated the enactment of a legislative bill designed to improve the South Carolina Probate Code. There is an almost unanimous opinion by the membership that the Probate Code should be revised to establish a process for probating estates with a savings of time and costs. An incalculable number of words have been written and spoken on this subject. Although progress has been made toward enactment of an appropriate bill, the goal has not yet been reached. We sincerely hope that 1985 will be the year in which it will be attained.

The reassessment of property and the levying of higher and higher property taxes have made the present homestead exemption most inadequate for elderly people. The AARP maintains that increasing the homestead exemption to $30,000 is the best means for delivering property tax relief to older citizens. This is a very strong legislative priority of our constituents. We urge immediate passage of the appropriate bill.

The legislative priority item upon which I wish to spend the rest of the time allotted me is not only at the top of the list compiled by our committee, but it is also receiving primary attention by the National Legislative Council and the Board of Directors of AARP representing 16 million members of the organization across the nation. This priority refers to the critical need to restrain the extraordinary rate of increase in health care costs in general and hospital costs in particular. In this regard, the AARP has launched a nationwide health care campaign. We, the members of AARP in South Carolina, as well as our counterparts throughout the country, see cost containment as the single most important factor determining the quality of our health care.

Over one billion dollars a day is being spent in the United States on health care. Expenditures in this area have been skyrocketing at more than double the general inflation rate. At stake in this cost crisis is not only affordable health care for older Americans but also for all Americans. Hospital costs, in particular, have soared. According to Bureau of Labor statistics, the increases in hospital room rates have been two and one-half times greater than the increases in general price levels. Not only has Medicare been threatened by the health cost crisis, but private insurance plans have been also jeopardized.

In a speech before the American Hospital Association in Denver, Colorado on August 13, 1984, Vita Ostrander, national president of AARP, outlined AARP's policy proposals to slow health

care cost inflation. She said:

> AARP advocates a comprehensive approach to health care cost containment which focuses on negotiating -- or, if necessary, mandating -- limits on the rate of increase in payments to providers, especially hospitals, for all third-party payors, not just Medicare.
>
> Although AARP recognizes the recently enacted Medicare prospective payment plan as a step in the right direction, it limits only Medicare payments to hospitals. Because of the potential for hospitals to charge higher rates to other private and third-party payors in order to regain revenue lost from reduced Medicare payments, it will have little impact on controlling total hospital spending.
>
> AARP also supports legislation that would encourage the statesto adopt mandatory hospital rate review programs to assure that increases in payments to hospitals do not exceed the national limit and also to control the growth and expansion of hospital facilities.

We trust that our state will be in the vanguard of those enacting legislation to restrain the rise in health care costs. The health care cost crisis is a threat to both young and old.

We appreciate very much the attention that the State Legislature has given to the needs of older citizens in the past, and we solicit your continued support of this ever-growing segment of the population of South Carolina.

Arthur Clement, State Coordinator
Citizen Representation Program
AARP

The AARP's objective is to increase older citizen representation on boards and commissions in South Carolina. Much progress has been made in the past few years which was mainly due to the assistance of the Study Committee on Aging. Mr. Clement urged the Committee not to cease their efforts in this area.

He referred to S-662, a Resolution urging the Governor to appoint more older citizens to State Boards and Commissions. The Governor responded to Chairman Rubin that 33 percent of all State Board and Commission members report their age as 60 and over. While this is commendable, Mr. Clement pointed out that all older appointees do not represent the elderly public interest--nor in many cases the general public interest. For example, a physician on the Medical Board is of no real value to them as citizen representative, as his/her interest will lie with the medical profession, regardless of age. However, the appointment of a non-pharmacist, in this case Mr. Hamilton, to the Pharmacy Board was an excellent choice as a consumer representative.

He recommended that in the future, when appointing a nominee to a professional board or commission his professional affiliation and ties to citizen organizations be examined which would give an indication of his/her ability to represent the public.

Good Morning.

I am Arthur Clement here today representing AARP's Citizen Representation Program. As you know, increasing older citizen representation on boards and commissions in the state of South Carolina has been an objective of ours for the past few years. We feel we have made much progress, with the generous and able assistance of the Joint Legislative Study Committee on Aging and it's staff. Where three years ago, few older citizens in the state were aware of their right to serve on a board as a citizen, now people from all over the state have at least begun to recognize such service as viable, legitimate and important.

I'd like to make two points to the Committee this morning. First, do not cease your efforts in this area. Though we have had a hiatus in our activities recently, we plan to have a full program again in 1985 and will need your assistance. The appointment of Mr. Lester Hamilton of Charleston in May to the State Pharmacy Board as its sole public member was a significant step in the direction we should continue to follow. Mr. Hamilton, incidentally, is joining the ranks of AARP officers who serve on state pharmacy boards in both Massachusetts and Arkansas.

My second point relates to Senate Bill 662, a resolution urging Governor Riley to appoint more older citizens to state boards and commissions. The Governor responded to Chairman Rubin that

fully 33% of all state board and commission members report their age as sixty years of age and over. I commend the Governor for this record but feel it is important at the same time to make a vital point: All older appointees do not represent the elderly or even the general public interest. For example, a physician on the Medical Board is of no real value to us as a citizen representative. Understandably, his or her interest will lie with the medical profession, regardless of age. Mr. Hamilton's appointment is an example of a non-professional -- non-pharmacist in this case -- being appointed to govern the practice of pharmacy in this state. His ability to speak from the consumer point of view is unquestionable because of his lack of formal affiliation with the profession. Mr. Hamilton's ties to citizen groups such as AARP representing the largest consumers of pharmaceutical products -- the elderly -- enhance his value as a consumer representative and more. My concrete recommendation is that in identifying candidates for nomination in the future, we always examine their professional affiliation and ties to citizen organizations as indicators of their ability to represent the public, consumer or citizen interest.

Thank you for your time this morning.

Col Herbert Weisberg (Ret.)
Legislative Forum
S. C. Federation of Older Americans
Columbia, SC

Colonel Weisberg outlined the following programs:

The Federation has been a joint sponsor of the Annual Senior Citizens' Day with the Legislature. Senior Citizens from all over the State attend this event to enjoy an educational program on subjects of interest to them and meet with their legislators at the State House.

An Annual Recognition Banquet for Working Older Americans has been initiated.

The Association's magazine, The Senior Circle, is the voice of all people interested in the problems of older citizens. It will serve as a means of communication and exchange of ideas between individuals and organizations.

The Legislative Forum meets monthly to discuss legislation of interest to the members. In this capacity the Forum has worked closely with the Committee on Aging and was able to help draft legislation of benefit to senior citizens; such as the Homestead Exemptions for senior citizens.

They have advocated the Community Long Term Care Project as an alternative to institutionalization.

Mandatory retirement at age 72 for State teachers and employees was another matter of concern.

The first Condominium Conversion Act was signed into law in 1983; however, much more must be done in the area of tenant protection for senior citizens. Important to note here is that a tax refund would not be a beneficial solution as many older tenants are so poor that they are not required to submit a tax return.

Health care cost containment is of maximum interest to the population as a whole, but especially to senior citizens. The organization members are ready to work with any group on this subject.

They hope that the Probate Code Revision will be realized soon.

The Association supports the following concerns:

1. Reintroduction of the Death with Dignity bill.
2. Public Transportation for senior citizens especially after dark and in the rural areas
3. More representation of senior citizens as lay and consumer members on State Boards and Commissions.
4. Possibility of a Golden Card to identify older Americans for shopping discounts. They are hoping that this will lead to identification for reduced fares, elimination of sales tax on food. This exists now for prescription drugs and for other benefits as they now are available in other states.

SENATOR RUBIN, MEMBERS OF THE COMMITTEE. I AM HERBERT WEISBERG, PAST PRESIDENT OF THE SOUTH CAROLINA FEDERATION OF OLDER AMERICANS. THE FEDERATION IS CHARTERED AS A TAX EXEMPT VOLUNTEER ORGANIZATION IN SOUTH CAROLINA, WHOSE MEMBERSHIP IS OPEN TO ALL PEOPLE, REGARDLESS OF AGE, WHO ARE INTERESTED IN ANY PROGRAM THAT AFFECTS THE WELFARE OF THE STATE'S OLDER CITIZENS. ALTHOUGH WE ARE NOT A STATE AGENCY, WE ENJOY A GOOD WORKING RELATIONSHIP WITH MANY OF THESE AGENCIES. WE WISH TO EXPRESS OUR APPRECIATION TO AND ADMIRATION FOR THIS COMMITTEE, ESPECIALLY TO SENATOR RUBIN AND KELLER ~~BUMGARDNER~~ BARRON FOR THEIR COOPERATION WITH US AND FOR THEIR ACCOMPLISHMENTS.

WITH THE LIMITED TIME AVAILABLE, I CANNOT DISCUSS ANY OF OUR PROGRAMS IN DEPTH, BUT WILL ATTEMPT TO OUTLINE THEM BRIEFLY. THE FEDERATION HAS BEEN A JOINT SPONSOR OF THE ANNUAL SENIOR CITIZENS' DAY WITH THE LEGISLATURE. SENIOR CITIZENS COME FROM ALL AREAS OF SOUTH CAROLINA TO ENJOY AN EDUCATIONAL PROGRAM OFFERED ON SUBJECTS OF INTEREST TO THEM AND TO MEET WITH THEIR LEGISLATORS AT THE STATE HOUSE. WE HAVE HAD APPROXIMATELY 200 AT EACH OF THESE MEETINGS. WE HAVE INITIATED A PROGRAM OF AN ANNUAL RECOGNITION BANQUET FOR WORKING OLDER AMERICANS. OUR MAGAZINE, THE SENIOR CIRCLE, WHICH HAS RECENTLY BEEN RESURRECTED, IS A JOURNAL WHICH WILL BE THE VOICE OF ALL PEOPLES INTERESTED IN THE PROBLEMS OF OLDER CITIZENS. IT WILL SERVE AS A MEANS OF COMMUNICATION AND EXCHANGING OF IDEAS BETWEEN INDIVIDUALS AND ORGANIZATIONS.

THE LEGISLATIVE FORUM, SPONSORED BY THE FEDERATION, CONSISTS OF INDIVIDUALS AND REPRESENTATIVES OF ORGANIZATIONS OF RETIREES AND SENIOR CITIZENS WHO MEET MONTHLY TO DISCUSS LEGISLATION OF INTEREST TO THE MEMBERS. IT IS IN THIS CAPACITY THAT WE HAVE WORKED CLOSELY WITH THIS COMMITTEE. WE HAVE HELPED IN DRAFTING LEGISLATION AND HAVE TESTIFIED AT HEARINGS ON THESE BILLS. WORKING WITH OTHERS, WE HAVE SUCCEEDED IN HAVING HOMESTEAD EXEMPTIONS FOR SENIOR CITIZENS INSTITUTED AND INCREASED TO ITS PRESENT AMOUNT. WE HAVE ADVOCATED THE COMMUNITY LONG TERM CARE PROJECT AS AN ALTERNATIVE TO INSTITUTIONALIZING PATIENTS. THE MANDATORY RETIREMENT AT AGE 72 FOR STATE TEACHERS AND EMPLOYEES WAS ANOTHER SUBJECT OF CONCERN TO US. ALTHOUGH THE FIRSTCONDOMINIUM CONVERSION ACT WAS SIGNED INTO LAW ON MAY 20, L983, THIS WAS JUST A FIRST SMALL STEP. MUCH MORE MUST BE DONE IN THE AREA OF TENANT PROTECTION FOR SENIOR CITIZENS. HAVING A TAX REFUND AS A SOLUTION WOULD NOT BE BENEFICIAL TO THE MANY OLDER POORER TENANTS WHOSE INCOMES ARE BELOW THE LEVEL REQUIRED FOR SUBMITTING A TAX RETURN.

OF PRIME INTEREST TO SENIOR CITIZENS, AS WELL AS TO THE POPULATION AS A WHOLE, IS THE PROBLEM OF HEALTH CARE COST CONTAINMENT. THE MEMBERS OF OUR ORGANIZATION ARE READY TO WORK WITH ANY GROUPS ADDRESSING THIS SUBJECT. WE HAVE WORKED ON THE PROBATE COURT REVISION AND HOPE TO SEE OUR EFFORTS COME TO FRUITION SOON. ALTHOUGH THE DEATH WITH DIGNITY BILL FAILED TO PASS, WE ARE HOPE-

FUL THAT A REVISION OF THIS BILL WILL BE REINTRODUCED WITH PROVISIONS TO MAKE IT MORE ACCEPTABLE. WE KNOW THAT THERE STILL ARE SOME VACANCIES FOR SENIOR CITIZENS AS LAY AND CONSUMER MEMBERS ON SOME STATE BOARDS AND COMMISSIONS. WE ARE COORDINATING OUR EFFORTS IN THIS AREA WITH THE AARP. WE FEEL THAT MORE SHOULD BE DONE IN THE AREA OF PUBLIC TRANSPORTATION FOR SENIOR CITIZENS. MANY OLDER PEOPLE WHO HAVE THEIR OWN TRANSPORTATION CANNOT DRIVE AFTER DARK AND THUS ARE HINDERED IN THEIR DESIRE TO PARTICIPATE IN EVENING ACTIVITIES. BUS SERVICE AFTER DARK IS ALMOST NON-EXISTENT, ESPECIALLY IN RURAL AREAS.

THE FEDERATION IS NOW RESEARCHING THE POSSIBILITY OF THE ISSUANCE OF A GOLDEN CARD TO IDENTIFY OLDER AMERICANS FOR SHOPPING DISCOUNTS. WE ARE HOPEFUL THAT THIS MAY SOME DAY LEAD TO IDENTIFICATION FOR REDUCED FARES, ELIMINATION OF THE SALES TAX ON FOOD AS IT NOW EXISTS FOR PRESCRIPTION DRUGS, AND FOR OTHER BENEFITS AS THEY ARE AVAILABLE IN OTHER STATES.

AS YOU REALIZE, MANY OF OUR PROGRAMS ARE NOT OURS EXCLUSIVELY. HOWEVER, WE ARE READY TO WORK WITH OTHERS TO SUPPLEMENT THEIR EFFORTS IN ALL THESE AREAS. WE <u>WILL</u> CONTINUE OUR ROLE AS ADVOCATES FOR <u>ALL</u> OLDER AMERICANS IN SOUTH CAROLINA.

Samuel J. Washington, Exec. Director
Midlands Human Resources Development Commission
Columbia, S. C.

Mr. Washington appeared on behalf of many aging persons in the Midlands as well as persons who participate in programs that are funded through several block grants that end up being administered by community action agencies. They include the Community Services Block Grant, the Low Income Home and Assistance Program as well as a combination of other support systems that their agencies through the Division of Economic Opportunity provide to improve the quality of life for persons in the State.

He briefly reaffirmed the commitment of the community action agencies along with the other legislative and administrative bodies to say that the aging population in the State should continue to enjoy the quality of life that is available to other Americans.

I AM PLEASED TO APPEAR BEFORE THIS VERY IMPORTANT COMMITTEE TO SHARE WITH YOU THE CONCERNS OF ELDERLY PERSONS OF THE MIDLANDS.

OUR AGENCY IS BEING AFFORDED THE UNIQUE OPPORTUNITY OF SERVING CLIENTS IN SUCH AREAS AS: ENERGY ASSISTANCE, HOUSING, EDUCATION, MEDICAL ASSISTANCE, NUTRITION, AND TRANSPORTATION.

AS A RESULTS OF THESE OPPORTUNITIES THAT OUR AGENCY EXPERIENCES, WE ENCOURAGE THE STATE TO MAKE CERTAIN THAT OPPORTUNITIES FOR ELDERLY ASSISTANCE AND MEDICAL SERVICES BE MADE AVAILABLE TO OUR ELDERLY POPULATION WHO HAVE GIVEN THEIR BEST TO OUR NATION, STATE AND LOCAL COMMUNITY.

IT IS URGENT THAT THE LEGISLATURE TAKE IMMEDIATE STEPS TO ASSIST ELDERLY CLIENTS IN THE AREAS OF MEDICAL ASSISTANCE AND TRANSPORTATION.

THE COMMUNITY ACTION AGENCIES ALONG WITH OTHER PROVIDERS ARE READY TO HELP, GIVEN THE OPPORTUNITY FOR PARTICIPATION AND PLANNING THESE IMPORTANT SUPPORT SYSTEMS.

Edward W. Rushton, Exec. Director
Orangeburg County Council on Aging
P. O. Box 1301
Ornageburg, SC 29116-1301

At previous annual public hearings of this Committee, Dr. Rushton's testimony centered upon several basic needs of senior citizens: senior citizens centers and transportation systems for the elderly. He expressed his appreciation for the understanding and suggestions received from the Committee. The Committee's challenge was to "get on with the job and solicit support and moral assistance from individuals, groups, organizations and the county governing body."

The transportation problem is statewide, particularly in the rural areas. Some relief has been obtained by granting volunteers who provide transportation services to senior citizens 14 cents/mile deduction on state income tax returns. However, the basic needs still exist. In Orangeburg County the only public transportation is taxi service, which is very expensive. The Community Action Agency provides limited transportation in the environs of Orangeburg City. In the rural areas, with car pools practically non-existent, there is no other transportation available.

Dr. Rushton is not advocating a free transportation system but bus transportation service at affordable costs to individuals who want to come for community services. He urged the Committee to continue their good services to help relieve this number one problem of need.

He described the devastating fire in November 1983 which destroyed the Orangeburg County Council on Aging facility. Through the cooperation and help of practically every member in the community--from businesses, service agencies, county officials to county council--they were able to rebuild the center and are back in business with a modern facility of 19,000 sq. ft. The agency personnel is working to restore programs and services and moving forward to improve and expand them.

In closing, Dr. Rushton invited the Committee to an Open House on Sunday, October 21, 1984, from 3-5 P.M.

THE JOINT LEGISLATIVE STUDY COMMITTEE ON AGING

PUBLIC HEARING

SEPTEMBER 20, 1984

BLATT BUILDING,ROOM 101/109, COLUMBIA, S.C.

Mr. Chairman, Members of the South Carolina Study Committee on Aging:

On several previous annual public hearings of your Joint Legislative Study Committee on Aging my testimony centered upon several basic needs of senior citizens, viz: Senior Citizens Centers and Transportation Systems for the elderly.

Your committee members afforded me a sympathetic and caring audience concerning these urgent responsibilities. You also made suggestions about procedures in the interest of either alleviating the problem of inadequate and obsolete physical structures or find ways of improving outmoded facilities. You emphasized that solutions were a local responsibility. I think you implied also that those of us on the local level should energize our efforts to exhibit the needs for not only physical facilities but also for more adequate programs/services for older persons. In brief, your challenge was to get on with the job and to solicit support and moral assistance of individuals, groups, and organizations, including the county governing body.

With respect to transportation for the elderly, you indicated that this was a vital problem state-wide, particularly in rural areas. Some relief has been made in that volunteers who provide transportation for services to senior citizens may claim 14¢ per mile on state income tax returns. This consideration is certainly appreciated; however, the basic need persists.

In Orangeburg County, for example, the only public transportation is taxi service which is too expensive. The Community Action Agency provides limited bus transportation in the environs of Orangeburg City. In the rural areas, car pools which are practically non-existent, there is no other transportation available. Herein, lies the problem. I am notadvocating free rides to our center but transportation service at affordable costs. In my opinion, our Senior Center is set up to serve county-wide participants with a wide range of programs/activities; however, many deserving but low-income elders are deprived of these benefits. I urge you to continue your good services to help relieve this number one problem of need.

Briefly, I shall describe the situation regarding a new, adequate and well equipped Senior Citizen Center recently completed in Orangeburg County.

In November 1983 a devastating fire destroyed the Orangeburg County Council on Aging facility. Everything was gone -- equipment, furnishings, financial records, food supplies, state and federal reports, etc. Following the holocaust the smoldering ruins were ransacked for anything remaining, but to no avail.

The community was in a state of shock. With no place to go, no office equipment or supplies -- not even a lead pencil, devoid of any semblance of rcords or reports and destruction of our on-site nutrition program, our employees and participants were distraught. Whereupon, business establishments, service agencies, county administrator and county fair officials responded magnificently.

Temporary space for essential functions were provided immediately by county council, furnishings such as desks, chairs and minimum equipment came from a service agency. Business establishments responded with office equipment and supplies. Another community agency and school district 5 provided nutrition sites and meals were catered by a profit-making vendor.

Pursuant to several temporary moves over a period of several months together with a restoration of essential services, Orangeburg County Council approved the use of a new facility and subsequently appropriated sufficient funds to renovate the building consistent with requirements for a modern Senior Center.

Following this tremendous contribution of County Council, the problem arose with respect to equipment, furnishings and supplies. With perseverence and the strong support of our Senator and our Governor, together with fire insurance income, our agency received funding for equipment and furnishings.

Our staff deserves all the accolades that could be given. They verified destroyed records with the assistance of a local bank researching financial accounts, established losses accepted by the insurance company, verified social service reports acceptably, and we are now working with a CPA auditing firm to put together data to present detailed information in accordance with generally accepted accounting standards. Our agency personnel is ardously working to restore programs and services and

to move forward in improving and expanding services made possible by our new and adequate Council on Aging home base.

The story is concluded with succinct remarks, as follows: (1) Orangeburg County Council on Aging is now in business with a modern and renovated physical facility consisting of 19,000 sq. ft.; (2) brand new kitchen equipment capable of preparing daily meals on a tri-county basis; (3) a dining room at the Orangeburg congregate site including a stage, space for social, educational and the entertaining arts; (4) recreational areas for a broad spectrum of activities, such as physical exercises, fine and practical arts, educational classes, audio-visual aids, library and reading area, game room, lounge, board room, photography, and reception area for visitors and participants; and, (5) offices and auxiliary equipment for efficiency in serving senior citizens.

In conclusion, Orangeburg County's new and permanent home for the elderly is located in a desirable neighborhood at the Human Resources Center, ready access to shopping centers, the Orangeburg Regional Hospital and doctors' offices, and contains sufficient parking for busses and cars. We have scheduled an Open House on Sunday, October 21, 1984, 3:00-5:00 p.m. You are cordially invited to view the facility and rejoice with us in a modern miracle for senior citizens.

Respectfully submitted,

Edward W. Rushton

Edward W. Rushton
Executive Director
Orangeburg County Council on Aging

Dr. Evander M. Anderson, Chairman
Senior Program
S. C. Dental Association
1108 Calhoun Street
Newberry, SC 29108

Mr. James Dubs, Deputy Director, S. C. Commission on Aging, helped the Dental Association formulate the "Senior Care Program." It was initiated July 15, 1982 and is an innovative effort between the public and the private sector to offer high-quality dental care at reduced fees to the eligible elderly and was developed following an Association's members survey of access and subsequent appointment of an Access Program Committee. This Committee reviewed similar programs in operation in other states and studied guide lines from their work and dental associations in an effort to reduce dental costs and services for South Carolina's eligible elderly.

With the participation of the Commission on Aging, an in-depth study of the needs of the elderly was begun to determine the basic eligible income to qualify and methods of presenting this to the dental profession of South Carolina in a comprehensive manner to insure participation.

The Commission on Aging screened all applicants to determine eligibility (65 and over and a spendable income of less than 60 percent of median family income, which in 1982 was $8,223 for couples and $6,288 for singles) and to refer patients to the participating dentist of their choice.

Letters containing the administrative procedures for the program were sent to all members of the S. C. Dental Association requesting their participation. To date over 600 dentists have signed up to participate in this program. This does not include specialists (orthodontists, oral surgeons).

Persons who qualify are invited to participate in this program and to call the dentist of their choice. Their county council will give them all the information they need. A 20 percent discount is given on all dental services which includes dentures. These services are also provided in nursing homes.

Senator Rubin commented that this is a very forward move and sounds very encouraging.

Rep. Waldrop praised Dr. Anderson for his work.

Dr. Anderson added that every county in this State has one or more dentists who signed up in this program.

(Additional written material is on file in the Committee).

South Carolina Dental Association
A Constituent of the American Dental Association

723 Queen Street ▪ (803) 799-3649 ▪ Columbia, South Carolina 29205

The South Carolina Dental Association has placed a high priority on the needs of senior citizens. We would like to take this opportunity to inform you that we have been working with the Commission on Aging for several years now with respect to the special problems the elderly face with dental care.

Those special problems are both complex and compound. The dental needs of the elderly are complex because there is a high probability in the later years of life that a patient will require extensive and expensive restorative work. This is compounded by the fact that many senior citizens live on limited and fixed retirement incomes and therefore may neglect seeking care they believe they cannot afford.

For all these reasons, the South Carolina Dental Association has been participating with the Commission on Aging in the Senior Care Program. Under this program, the Commission determines eligibility and makes referrals to participating dentists, who have agreed to give substantial discounts to the elderly.

Also, I'm happy to say that, with a very limited effort at recruitment, we have enjoyed a very high degree of participation by the dentists of South Carolina over the last two years.

On a more recent note, however, I would also like to report that our Public Relations Committee met recently to discuss ways we can increase our involvement in this worthy program. We have talked about the production of an informational brochure which our dentists could distribute through their offices and possibly some promotion of the senior care service through the news media and public service programming on the television stations.

Of course, our plan to enhance involvement in senior care is at a preliminary point. Whatever we do must be coordinated with the Commission on Aging. And I'd also like to take this opportunity to commend the Commission on the outstanding work they do in support of elderly citizens in South Carolina.

Thank you for this opportunity to report to you on behalf of the South Carolina Dental Association, for your concern for the welfare of our State's citizens, and finally thank you for your courteous attention during this brief report.

DR. Nicholas Mandanis
President
SCDA

Dr. Evander Anderson
Chairman, Senior Care Program
SCDA

E. M. ANDERSON, D. D. S.
1108 CALHOUN STREET
OFFICE PHONE 276-0940
NEWBERRY, S. C. 29108

Topic: South Carolina Dental Association Senior Care Program

Effective Date: July 15, 1982

Chairman: Dr. E.M. Anderson, Sr.

Associates: Dr. Lynn Campbell, President Of S.C.D.A. (1982)
Mr. James Dubs, Deputy Director- S.C. Commission on Aging

The Senior Care Program which is an innovative effort between public and private sectors to offer high quality dental care at a reduced fee to the eligible elderly was developed following an association membership survey on access and subsequent appointment of an Access Program Committee. This committee reviewed similar programs in operation in other states and studied guide lines from the American Dental Association to offer a reduced cost dental services program for South Carolina's eligible elderly.

Dr. Lynn Campbell, President of South Carolina Dental Association at that time, Myself(Dr. E.M. Anderson, Sr.) as Chairman of the committe for Health Care Needs of the Elderly, and Mr. James Dubs, Deputy Director of The South Carolina Commission on Aging began an in depth study of the needs of the elderly, the basic eligible income to qualify for reduced cost of services, and methods of presenting this to the dental profession of South Carolina in a comprehensive manner to insure participation.

The South Carolina Commission on Aging agreed to screen all applicants to determine eligibility and to refer patients to the participating dentist of their(patients) choice. Eligibility of the patients was determined that said patient must be over 65 years old and have a spendable income of less than 60% of median family income. At that time(1981-1982) that was $8,223. for couples and $6,288. for singles. This figure includes all Social Security benefits, dividends, interest, pensions, and annuities.

Letters containing the administrative procedures for the program were sent to all members of the South Carolina Dental Association requesting their participation in thi most worthwhile project. Each Dentist was asked to complete an official enrollment form. To date over 600 members from all counties in South Carolina have signed up to participate in this program.

South Carolina Dental Association Central Office(Mrs Mary Clary) agreed to serve as central recipient of each completed form stating dental services rendered to the patients and to compile a percentage list of services to the patients and participating dentists.

To date this program has been well received by the patients, The South Carolina Council on Aging and South Carolina Dentists.

Ms. Barbara Wright
S. C. Adult Day Care Association, Inc.
2010 State Street
Cayce, SC 29033

Adult day care offers an effective alternative for families who want to keep a disabled adult in the home instead of institutionalization. It should be looked upon as a step in the continuum of care, not a substitute for nursing home care. It is a place where a participant is cared for while family members work or take a day or two of respite. In addition, it offers the participant a chance to reach and maintain his/her maximum level of functioning by providing therapy, planned activity, regular exercise, hot meals, and socialization.

The decision where an individual will receive care should be his choice. To provide such a choice it is necessary to consider measures that will make alternatives to institutionalization more financially feasible for care givers.

In a recent survey of 4254 senior citizens residing in Richland and Lexington Counties 2921 were found to be possible candidates for adult day care. Ms. Wright urged members of the Committee to consider some sort of financial assistance for families who care for their own family members in their homes.

In closing Ms. Wright referred to the Community Services for the Frail Elderly Bill of which Adult Day Care is part and asked for support of this legislation.

Comm Serv for Elderly
Harry Bryant

Good afternoon. My name is Barbara Wright and I am cofounder of Helping Hands Adult Day Care in Cayce, S.C., and am here today to speak in behalf of the S.C. Adult Day Care Association.

Today I stand in proxy for a growing number of individuals and families who are finding themselves between the proverbial rock and a hard place. Families who have for various reasons made the decision to keep a disabled adult in the home in leiu of institutionalization.

South Carolina, like the whole country, is literally growing older. The segment of our population that is over the age of 60 is the fastest growing group in the country. As we grow older we should not lose the right to remain in our own homes, with as much independence and freedom as possible for as long as possible. And granted, most of our senior citizens are healthy and able to care for themselves, but if and when the time comes that an adult can no longer remain alone and unsuprivised in their homes it becomes the decision and responsibility of their family concerning what will be done.

Today many families are deciding to try and keep their loved ones at home This is when they often find themselves between that rock and the hard place. For children keeping a dependent adult there are often jobs that are necessary to the financial survival of their own families that cannot be sacrificed to stay during the day with their disabled loved one. Good reliable sitters are often very hard to find and even harder to keep. For a spouse or relative who does not work outside the home and becomes the caregiver there is the very real need for a day or two of rest and relief during the week.

Adult day care offers a creative and effective alternative for these families. It offers a daytime situation where a participant is not only tenderly cared for while family members work or take a well deserved day of rest, but a situation where through therapy, planned activity, individualized goal oriented care plans, regular exercize and hot meals, not to mention support groups, professional services, community involvement, and socialization, they can reach and maintain their maximum level of functionin

Adult day care should indeed be looked upon as a step in the continuim of care. Not a substitute for nursing home care, bu t a viable alternative for qualifying individuals and families who opt to keep a loved one at home for as long as is benificial to the individual.

I think that we as a state should seriously consider the need for some financial assistance and political support for those who choose day care as a solution to the problems generated by the choice of keeping a dependent adult in the home.

The decision of where an individual will recieve care should be thier choice. It should be their right as an American citizen to have the choice as to where and how they spend their later years. Due to financial problems to protect this right for many families- indeed to even provide a true choice we need to consider measures that will make alternatives to institutional care more financially feasible for the care giver and their families.

In a recent survey of 4254 senior citizens residing mainly in Richland and Lexington County 2921 are possible candidates for adult day care, due to physical and mental impairment that lend to the need for supriviision. We feel this is indicative of a very real need statewide for the services provided in alternative care situations.

We strongly urge our state representatives to take a long hard look at what our state offers our aging population in the area of choices for the way they spend their lives after they become less able to care for themselves due to a stroke, heart disease, or some other debilitating condition. We believe that we all deserve the dignity of choice and the right to stay in our own homes, among our own people for as long as is possible. We also would urge you, distinguished panel, to consider some sort of financial assistance for families who take on the challenge and responsibility for the care of their own family member. Then and only then will there truly be a choice for many S.C. families.

So, I stand here today in proxy- in proxy for a needy segment of our population who can not easily stand here for themselves- a people who have worked hard, paid taxes, raised families, stood on their own two feet, built homes and lobored in their respective communities to make them what we enjoy today, but have come to a time in life when they ar now dependent on their families, and indeed us- they need our support and our help. They deserve the best and certainly the right to a choice- and for some that would be the choice to remain in their homes as long as they are physically able to. Adult day care can provide that choice. Let us not allow the lack of financial assistance for such a reasonable alternative keep families apart, take our deserving elderly citizens out of their own home and make institutional care the only choice- let us assure that dignity of choice for them by taking some steps to offer some financial assistance for alternative care for the dependent adult.

Ms. Ann Chadwell-Humphries
S. C. Adult Day Care Association, Inc.
2010 State Street
Cayce, SC 29033

The Association is composed of individuals directly involved with the operation or formulation of adult day care centers. Ms. Humphries discussed fire regulations.

The Problem: Fire regulations are subject to the interpretation of local authorities and tend to be inconsistent and unusually strict for day care. There are only twelve in the State, Fire Authorities are uncertain as to how to treat them. They want to protect the public, but because of that they end up being a little strict to meet the codes. This is an unnecessary barrier to operators who attempt to fill the gap between acute care institutionalization and home care. She read from the Act provided for the licensing of adult day care and established their minimum standards: "The term adult day care shall not be synonimous with terms of foster home, halfway house, boarding home, residential care facility, nursing home or group care home." Day care is open only from 4-14 hours a day, but does not require as strict a regulation.

Solution: Organize a task force to study this dilemma. Members should be the local fire authorities in areas where adult day care already exists, a representative from the State Fire Marshal's Office, operators from the adult day care facilities.

Rep. Harris asked who is proposing the task force and how will it be implemented.

Ms. Humphries explained that the Day Care Association is proposing it and they are looking to the Legislature for some options how to organize it.

Rep. Harris added that this will take legislative action and asked that they submit a proposal asking that the Legislature look at it.

Senator Rubin suggested that the Governor could create it.

Rep. Harris was of the opinion that the task force is the right approach.

Ms. Humpries said that they would be delighted to submit a draft according to Rep. Harris' suggestion.

September 20, 1984

TO: Senator Rubin, Members of the Commission, Ms. Barron

My name is Ann Chadwell Humphries. I represent the South Carolina Adult Day Care Association, Inc., which is composed of individuals directly involved with the operation or formulation of day care centers for adults. Adult day care offers a therapeutic day program of recreational activities, nourishing meals, rest periods, and medical therapies if needed in a safe pleasant atmosphere. There, whether they live alone or with the working relatives, the elderly can spend their days in a supportive environment making friends and participating in activities of their choosing. Knowing their relatives are safe, family members can continue with their work or other daytime activities without worry. Day care centers are open a minimum of four hours a day to a maximum of fourteen. No overnight stay is allowed under regulations. I wish to discuss fire regulations of these facilities.

The Problem: Fire regulations are subject to the interpretation of local authorities and tend to be inconsistent and unusually strict.

Comments: Because only twelve day care centers exist in South Carolina at this writing, and more are developing, fire regulation authorities are uncertain as to how to classify these facilities. To protect the participants, many of whom need assistance to walk, the authorities require unusual restrictions to meet codes. This is commendable; however, it serves as an unnecessary barrier to operators who are attempting to fill the gap between acute care and institutionalization and home care. I would like to read to you from Act 647 which provided for the licensing of adult day care centers and established minimum standards for their operation: "The term day care facility shall not be considered synonymous with the terms foster home, half-way house, boarding home residential care facility, nursing home or group care home."

Solution: Because day care is a viable alternative to existing health care settings, we, the Adult Day Care Association, Inc., would like to propose a task force to study the dilemma arising from the classification of adult day care centers. This task force we recommend should be composed of three groups: 1)local fire authorities from the areas where day care centers are in operation, 2)State Fire Marshall, 3)operators of day care facilities. Through the dialogue created in this arena, a solution could be found to not only protect the public, but also to encourage the growth of this vital service.

Thank you for the opportunity to appear at this hearing. We appreciate the hard work and commitment of the Committee for the elderly, a wonderful resource of the State

(Retyped from original letter)

Dr. Emily S. Wiggins
Family Life & Human Development Specialist
Clemson University Cooperative Extension Service
Clemson University
Clemson, SC 29631

This testimony dealt with the elderly as a valuable resource or as a liability.

Dr. Wiggins suggested that we involve the elderly in various activities which prevent them from dying emotionally and socially. In other words, give them some purpose in life. One excellent suggestion was to have programs match up one lonely elderly with one lonely youth.

A program that promotes interaction between youth and the elderly is Those Rich In Experience. This program is offered by the Clemson University Cooperative Extension Service in each county of the State. For more information on this program see the following page.

Dr. Wiggins asked the Committee if one of the members would talk to her about whether or not they have someone looking at what needs in the State can be best met by volunteer elderly people.

Senator Rubin answered that there are a variety of programs that are implemented through the local Councils, there are no barriers, it is a matter of manpower. "Do you have any specifics in mind or are you just raising the question in general?"

Dr. Wiggins replied that she is raising the question and was hoping that he would think about having someone on this Committee as sort of a "gatekeeper" to watch out for needs in our State that could be met by some elderly people who would volunteer to do this. She concluded by making this a request to the Committee.

Dr. Holler added that it was hard for the younger people to ask the elderly; in addition it is difficult for the elderly to break into institutions which do not use anybody who is no longer connected with them. If you can break those two barriers, time does not permit to enumerate all the things the elderly can do. As one example he referred to schools in the State that utilize the elderly as "grandparents."

In closing Dr. Wiggins said that she hopes the Committee will use every opportunity to help the society in South Carolina see the advantages of using the elderly wherever and whenever possible.

Our Elderly,

Valuable Resource of Liability?

Our elderly citizens can be one of our most valuable resources or they can be one of our biggest liabilities. Decisions we make in this legislature can lock us into one or the other.

Let's look at both ends of the see-saw. First our elderly as liabilities. Since we die three ways (emotionally, socially, and physically) and since the first two often occur long before the third) we can spend large amounts of state and individual money on the physical care of elderly people who have already died emotionally and socially because they had no purpose in life and no real involvement. We may have to purchase mental treatment and care for them. We can also pay sitters to care for latch-key children and purchase people to teach our children the skills and traditional values we want them to have.

On the other hand we can involve our wise and caring elderly to help with some of our societal needs. For example, as 4-H club, girl scouts, and boy scouts leaders, and/or tutors.

Each South Carolina youth has a very real and immediate need of having an adult to look up to. This is often a problem with working parents. Shouldn't programs to match one lonely elderly and one lonely youth be expanded? We would be adding life to years instead of years to life. By involving our elderly we will save money both ways -- The resource needs for our society could be better met and some of the mental problems of our aging society would be prevented.

One program to facilitate interaction between youth and elderly is Those Rich in Experience. For more information about this program contact your local Clemson University Cooperative Extension Service or Emily Wiggins, Ed.D., 246 Plant and Animal Science Building, Clemson University, Clemson, SC 29631; phone 656-3090.

Presented by: Emily S. Wiggins, Ed.D.
Family Life & Human Development Specialist
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Mr. Mounter elaborated further on Dr. Wiggins' comments. He proposed implementation of legislative consideration in the area of additional tax incentives for volunteers. Working in the field of Home Economics with the Cooperative Extension Service, one of his major responsibilities is to serve as advisor to the S. C. Extension Homemakers Council, a statewide volunteer organization in all counties with a membership of 6,500. One of their basic goals is volunteering to help other people, through working in hospitals, libraries, rest homes. Thirty-two percent of this membership are over 65 and 36 percent between 51 and 65. Valuing the time these volunteers donated at the minimum wage of $3.50/hour, it is worth over 1.2 million dollars.

In 1980 there were approximately 416,00 people over 60 year of age, and this number is increasing each year. It is estimated that relatively few from this age group volunteer because (1) we do not ask them, and (2) we do not offer incentives. One form of pay may be recognition through certificates, publicity or other non-monetary reward. Another form of pay could be in the form of tax incentives. The income tax deduction of 14 cents/mile is one example, another would be an additional tax deduction. There must be a way to document the time the volunteers give, have it validated by a professional in the agency or organization for which it was done and equate this time to a dollar value for purposes of a tax deduction.

Dr. Parrish asked if he could present this proposal in the form of a draft to the Committee so that it could be directed to the proper legislative source.

Mr. Mounter said he did not have it in that kind of draft but would be willing to develop one or assist in developing some kind of a procedure.

Senator Rubin added that we will study it and see what can be done.

VOLUNTEER INCENTIVES

I am appearing before you today to propose an idea for legislative consideration in the area of additional tax incentives for volunteers. First, I congratulate the legislature on the action taken in the last session providing a state income tax deduction of 14 cents per mile for travel for volunteer services for charitable organizations.

I am an employee of Clemson University working in the field of Home Economics with the Cooperative Extension Service. One of my major responsibilities is to serve as advisor to the South Carolina Extension Homemakers Council. This is a statewide volunteer organization functioning in all counties with a membership of 6,500. It is a volunteer organization with one of its goals to educate and help others. Being a member of this organization means, in effect, that you are motivated to volunteer.

This particular organization has 32% of its membership, 2,078, over the age of 65 and 36% of its membership, 2,337, between the ages of 51 and 65. It is estimated that last year this group of volunteers spent 364,000 hours helping 52,000 people directly and nearly 1 million people in a less concentrated fashion. Valuing their time at a minimum wage of $3.35 per hour, this effort was worth over 1.2 million dollars.

In South Carolina according to 1980 figures, there are 416,144 people over the age of 60 and the number is increasing each year. I don't have statistics to support it, but best estimates indicate that relatively few from this age group volunteer. This means that this group of people is an untapped resource. To a large extent, this group of people is a forgotten segment of our society. We know that they exist, but we ignore them as much as possible. They can help and, in many cases, want to help; we just need to ask -- and, in my opinion, provide some motivation for them to get back in the main stream by volunteering.

Senior citizens have lived a few more years than most of us and, as a result, have that "practical education" that is only learned through experience. People in this age group are our "experts" on living and on change. They have experienced change and learned to adjust to change as a necessity of living through a period of time when we have experienced the greatest changes in our history.

Volunteers extend our resources. They multiply our effort and reach many more people than our limited number of organization and agency professionals can. They can do many things that we cannot do or do not have the time to do and, many times, do them better than we can.

How do we get people to volunteer? We first have to ask them, and we should ask them to do something they can do. We should involve them in the planning, so they know what the job is and what is expected. Finally, we provide them with the motivation, incentives, and rewards necessary to make it attractive to them to volunteer. Expanding on this last item, we might ask ourselves why people volunteer. In almost all cases, it boils down to "What will I get out of it?" or "What is the pay?" Their reward or pay may be the good feeling and/or self-satisfaction felt by helping others. Another form of pay may be the recognition received through certificates, publicity or other non-monetary reward.

Another form of "pay" or "reward" is in the form of tax incentives. The income tax deduction for mileage is one example. I would propose an additional idea in the form of a tax deduction:

> Consider the documentation by a volunteer of the time spent volunteering. Have this documented time certified by a professional in the agency or organization for which it was done. Have this time equated to a dollar value for purposes of a tax deduction.

Details could be worked out and a workable plan devised to make such a system work. I propose that this is a means of providing an incentive that would mean something to the pocket book of the volunteer.

We spend a lot of time and effort finding ways to save money for the senior citizens, to raise their benefits and protect their buying power on a fixed income. Here is a way to do that plus get a return on the investment. I propose that the cost benefit could be tremendous and, perhaps, stagger the imagination. I would like to recommend that serious consideration be given to this idea and volunteer my help to anyone interested in developing it further.

In closing, let me offer this thought for consideration. I heard a speaker from Washington, DC, make the following statement.

> "An agency or organization that does not have a volunteer base will in a few years cease to exist. In addition, an employee in that agency or organization that does not promote volunteering or work to develop volunteers is saying that he/she does not care if the agency or organization ceases to exist."

I agree with this statement and would add that volunteers are one of our most valuable natural resources. All of us need to recognize the volunteers, perpetuate their use, and try to increase their numbers.

Prepared and submitted by:

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Tim Cash, Director
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It has been ten years since the Adult Protective Services law was passed, which was primarily due to this Committee's support in 1974. South Carolina was one of the first five states in this nation to have a law specifically protecting the elderly and the disabled from abuse and neglect. Thirty states have followed our lead and the program has been recognized for its progressiveness. The Department has been requested by other states to make presentations and to appear before the U. S. House of Representatives, Harvard University, the National Council on Aging and the American Public Welfare Association based on what this Committee started ten years ago.

Last year saw passage of S-655, which amended the Code of Laws to provide procedures for the taking of an Adult in a Life-Threatening Situation into protective custody by law enforcement officers.

He requested that the Committee support the traditional line item in the 1985/86 Appropriation Bill in the amount of $35,000 for the Adult Protective Services Emergency Fund. This Fund has, for the past ten years, allowed DSS to provide emergency food, shelter, clothing and medical care for Adult Protective Services clients.

He cited statistics of abused adults, which show that last year saw a 20 percent increase of these cases. Since 1974, they have investigated over 15,000 cases statewide that were reported.

In 1983/84 DSS has provided the following in-home community services to keep clients in their own homes:

1. Alternate Placement and Management Services
2. Family Management Counseling Services
3. Homemaker Services
4. Social Support Services.

In addition to the above-named direct services, a number of services were provided by other State or local agencies through contract with DSS. Basically these services enable clients to stay in their homes with dignity and out of institutions.

In conclusion, Mr. Cash mentioned additional funding--received through the Jobs Bill and Block Grant money--for a very innovative program, referred to as Companion Sitters or Emergency Caretakers. As a result of these services 324 clients were served last year.

Rep. Blackwell referred to the line item of ten years and the money for the temporary relocation of a person in a life-threatening situation. He asked Mr. Cash to notify today the Director of the Greenville County DSS, who continues to oppose the idea of adults in life-threatening situations being removed because of her claim that there are no monies available.

Mr. Cash said that he will be glad to.

Senator Rubin recognized Mr. Harrison Reardon of the Adult Protective Services.

STATEMENT OF THE SOUTH CAROLINA DEPARTMENT OF SOCIAL SERVICES SUBMITTED TO THE STUDY COMMITTEE ON AGING FOR A PUBLIC HEARING ON THURSDAY, SEPT. 20, 1984.

Mr. Chairman and Committee Members:

My name is Tim CASH and I am the Director of Adult Protective Services for the State Department of Social Services. On behalf of the Department, we appreciate the opportunity of appearing before this Committee and submitting our comments for your consideration.

First, I would like to thank the Committee for being supportive in general of the Adult Protective Services Program. Specifically, this support was demonstrated last legislative session with the passage of Senate Bill 655 which amended the South Carolina Code of Laws Section 23-1-220 so as to provide a procedure for the taking of an adult in a life-threatening situation into protective custody by a law enforcement officer. Copies of this new law have been distributed to all 46 of our County Department Offices, as well as, to Family Court Judges, Solicitors, Chiefs of Police, and County Sheriffs. It is believed that this new law will allow us to be more responsive to the needs of abused and neglected adults, even though resources are limited for protective placements and alternative living arrangements.

Next, we request that the Committee support the $35,000 line item in the Department of Social Services FY 85-86 budget for the Adult Protective Services Emergency Fund. This fund is used to purchase emergency food, shelter, clothing, and medical care for adult protective services clients.

Continuing on the subject of Adult Protective Services, I would like to give the Committee an update on our statistics. The number of adults who were reported to have been abused, neglected, or exploited in our State in FY 82-83 was 2,137. Last fiscal year, (FY 83-84) saw an increase of 20% for a total of 2,563 cases reported and investigated by county staff. Since 1974, over 15,000 cases have been reported and investigated statewide. We expect substantial

increases in reporting in the years to come.

Also, in FY 83-84, DSS provided other services to our State's citizens as follows:

Alternate Placement and Management Services - A total of 1,565 clients received this service, the purpose of which is to arrange safe, supportive substitute placements in the community for adults unable to live independently.

Family Management Counseling Services - A total of 4,063 clients received this service, which is provided to individuals or families who require assistance in maintaining or improving their ability to manage their home, their finances and/or their family relationships.

Homemaker Services - provides a variety of in-home services, including personal care, were received by 4,175 individuals.

Social Support Services - served 225 people as a direct operation of the Colleton County DSS. These services provide day activities for adults who would be socially isolated, thereby increasing contact with others and building self-esteem and combating inactivity.

In addition to the above named direct services, the following services were provided by other state or local agencies through contract with DSS:

-- Family Management Counseling - 352 clients

-- Homemaker Services -- 764 clients

-- Adult Day Care -- 124 clients

-- Home Delivered and Congregate Meals -- 657 clients

-- Transportation -- 3,814 clients

-- Community Based Counseling -- 2,505 clients

-- Social Support Services -- 600 clients

-- Special Services for Handicapped and Disabled Adults -- 1,425 clients

In conclusion, additional Jobs Bill and Block Grant money allowed special sitters to stay with elderly or impaired adults and help maintain them in their own homes. Three hundred twenty-four (324) clients received these community based services.

Thank you again and we look forward to continuing our efforts on behalf of the vulnerable, elderly citizens of South Carolina.

Respectfully submitted,

Tim Cash

September 20, 1984

Dr. John P. Daniel, Director
Office of Public Health Dentistry
2600 Bull Street
Columbia, SC 29201

Dr. Daniel's testimony addressed the oral health of the elderly. About 50 percent of persons over 60 in the United States have suffered the loss of their natural teeth, and he assumes that the percentages in the over 60 age group are even higher. He based this on the fact that South Carolina children aged 5-17 have a nearly 25 percent higher incidence of tooth decay than the average US child in that age group. One of the factors adversely affecting the eating habits of older people is poor teeth. Other side effects are disturbances in speech, appearance and chewing. In addition this loss can cause depression and a feeling of inferiority.

Public health dental programs for the aging have been very limited in South Carolina as most of the efforts in this State, and in many others, have been directed toward the oral health needs of children. Dr. Daniel hopes that a variety of new initiatives will be undertaken to reduce the incidence of oral disease of South Carolinians.

He suggested the following points to improve the oral health problems of older Americans:

1. Expand dental services to older Medicaid eligible persons.

2. Expand dental services to nursing home residents by identifying dentists as regular health care providers in the same manner as physicians.

3. Develop an expanded array of preventive services for the aging through public health programs. Screenings could help identify problems at an early stage.

"Good oral health is cost effective, health effective and improves the quality and quantity of life."

Senator Rubin wondered why older people neglect their oral health; was it due to cost or indifference?.

Dr. Daniel thinks there are a number of reasons; some are not able to afford the dental and medical services that they need; some think it is inevitable and hereditary.

Rep. Harris asked for available figures on dental insurance in the private sector and wondered if most of the health insurance plans have dental coverage.

Dr. Daniel explained that dental insurance coverage has been the greatest growing sector in the health insurance industry. However, plans vary considerably and one that has no deductible on the prevention services is certainly much better in his estimation.

Rep. Harris added that we give all the retirees coverage through the State Employees Health Plan which now includes dental coverage. So, this will be one group of retirees who will at least be able to avail themselves of dental services.

Dr. Daniel said he will do his part in encouraging their use of this plan.

S. C. Department of Health & Environmental Control
Office of Public Health Dentistry

Oral Health and Aging

"Long in the Tooth", a very descriptive term associated with aging might more accurately be phrased "Long Gone With the Teeth". Approximately 50% of the people over age 60 in the United States have suffered the loss of their natural teeth.[1]

While specific data are not available for South Carolinians over 60, it can reasonably be assumed that the percentages for South Carolina are even higher than the national ones! This projection is based on the fact that South Carolina children age 5-17 have nearly 25% higher incidence of tooth decay than the average U.S. child in that age group.[2]

Another recent study in South Carolina shows that older adults do not avail themselves of regular dental care. The data from this study shows adults over the age of 55, average about one dental office visit per year[3].

What exactly are the implications on health of these alarming statistics related to our aging citizens? It is an acknowledged fact that one of the factors adversely affecting the eating habits of older people is poor teeth. Other studies have shown that disturbances in speech, appearance and chewing result from loss of teeth. These studies have further documented this loss oftentimes caused a state of depression and a feeling of inferiority because an important part of the person has been lost.[4]

1. FDA Consumer/September 1984
2. S. C. Dental and Pediatric Blood Pressure Survey/1982-83/S. C. DHEC, Office of Public Health Dentistry.
3. S. C. Dental Care Survey 1983/S. C. Office of Research and Statistical Service.
4. Journal of Prosthetic Dentistry/April 1984.

Public health dental programs for the aging person have been extremely limited in South Carolina. Most of the efforts in this state, and in many others, have been directed toward the oral health needs of children. This approach was probably correct in view of the tremendous oral disease problems seen in children and the sparse resources devoted to public health dentistry programs and activities. However, no program can be considered successful that leaves unmet the needs of a substantial, and growing, number of our total population. It is my hope that a variety of new initiatives will be undertaken in South Carolina to reduce the near universal incidence of oral diseases in our people. Oral diseases and developmental disorders must be identified early, treated appropriately and prevented whenever possible so that the children and the aged of tomorrow will not have the severe problems we see today. The national initiative to improve the health of older Americans also identified oral health concerns as one of the major ones affecting this age group. It stresses the importance of health promotion to reduce oral/dental problems and notes the importance of life long dental care for everyone.[5]

Some of the specifics that it might be possible to consider immediately in our state are: an expansion of services to older Medicaid eligible persons. Dental Medicaid has been one of the very few areas within the overall Medicaid program which has consistently been within its alloted budget. It, therefore, seems only logical that some expansion of services or eligibility would be reasonable rather than using these funds to "reward" other areas of Medicaid that are consistently over budget.

5. A Healthy Old Age/U. S. Department of Health and Human Services Source Book

Second, it might be possible to expand dental services to nursing home residents by having similar oral health requirements as those related to other facets of health care. Auxiliaries could be encouraged to participate more in providing services to nursing homes and dentists could be identified as regular health care providers here in the same manner as physicians.

Third, an expanded array of preventive services could be developed for the aging through public health programs. Dental health education can be useful to adults as well as to children. Screenings for periodontal disease, oral cancer and other conditions can be very valuable in identifying problems at an early stage when they are most ameanable to resolution.

In closing, I wish to state that I have intentionally kept this comment brief. Not because of a scarcity of information on oral health concerns in the aging, but because it is important that people in the decision making seats have time to read this report and accept the challenge before us. Poor oral health is not an inevitable consequence of aging. Great strides have been made in dentistry and we owe it to our older citizens to bring these improvements into their lives. Good oral health is cost effective, it is health effective, and it immeasurably improves the quality and even the quantity of life.

Thank you for this opportunity to bring this concern before you. If I can be of further assistance to you in defining oral disease problems or with program plans, I am at your service.

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Tom Brown, Deputy Director
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A brief report was given on the progress of the Community Long Term Care Project in Spartanburg. State FY 83-84 was the last year of the CLTC Research and Demonstration Project. Effective July 1, 1984 the transition from the research and demonstration activity was made to the statewide system. During the phase-out period (April to June 1984) over 1,500 individuals who were Project participants-- either in the control or experimental group--were phased out of the Project. On July 1, 337 clients who were at home receiving community-based services (at the skilled or intermediate level of care or could have entered a nursing home) continued into the statewide Program. These persons are still continuing to receive services at home under the research waivers that are continuing at least until the end of this calendar year.

The other major activity that has occurred in the last year has been the completion of the evaluation of the Project by the Berkeley Planning Associates of Berkeley, California. The findings (on page 2 of this testimony) are very consistent with the thoughts given in earlier testimony to this Committee: the impact on the clients of being able to remain at home poses no problems as compared to the control group which used primarily nursing home care. There were statistically significant differences in the use of nursing home care by the experimental group. In the area of cost, the BPA confirmed their earlier findings that this type of system with community care being available does not cost more than the current system does.

The final report for the Project will be completed by the end of this year or first of next year by Project staff. A phase-out meeting, the formal closing of the Project will be in Spartanburg in October and members of the Committee will be invited.

One of the more important remaining activities of the Project relates to securing the Federal approval for the major service expansion for which this Committee helped obtain the funding through the appropriations process last year. They are in the process of securing 2176 waivers from the Health Care Financing Administration which has been under review since April and should be resolved in the next 90 days. This will allow them to draw Federal Medicaid match for the major service expansion. However, there are some problems with this review.

It would be helpful if the Committee could contact Dr.Carolyne Davis, Administrator of the Health Care Financing Administration, Baltimore, Md. and indicate their support and interest for this waiver. Senator Thurmond and Representative Campbell are also assisting with this application.

Senator Rubin assured Mr. Brown that this will be done.

Another item for Committee consideration is the concept of mandatory pre-admission screening for everyone who would like to enter a nursing home. Presently the CLTC Program conducts such a program for Medicaid applicants. About one-third of the referrals to the CLTC Program are people who are already residents of nursing homes and are converting from private pay status to Medicaid status. A survey conducted recently indicated that within 90 days 35 percent convert, within six months 54 percent and within a year 70 percent.

Rep. Harris asked how much increased staff would be involved and what would be the cost of the mandatory pre-admission screening.

Mr. Brown does not think it would take any increase in staff because ultimately everyone is converting to Medicaid so that is already staffed to handle the work load.

Rep. Harris asked what percentage of nursing home population is non-Medicaid.

Mr. Brown said at any one time 15-20 percent are private paid. But as he already indicated, 70 percent of those who enter as private pay will convert to Medicaid. Sometimes, unfortunately these individuals applying for Medicaid sponsored nursing home care do not meet the medical criteria established for the Medicaid Program in a nursing home. The availability of pre-admission screening even as a private paying patient will allow them to consider other options that are appropriate. This will avoid the unfortunate circumstance in which they many times find themselves of having to spend their resources. Georgia and Virgina and several other states have this type of legislation. He recommended that the Study Committee evaluate this proposal and consider the possibility of proposing legislation to introduce it.

Senator Rubin asked if this would not automatically run into opposition of the nursing homes.

Mr. Brown replied that eventually it would. On the other hand it would indicate that those people who have the screening were appropriate for nursing home care. It would be a valuable service to the private paying patients.

Another concern deals with Long Term Care Insurance. Not much has been heard of this type of insurance as it is not generally available in the country. Presently, 60-70 percent of long term care services are provided by family and friends; however, it is the 30-40 percent that we are concerned with. A 1981 study has indicated that about 44 percent of all nursing home expenditures were from private sources and out of that 44 percent almost 100 percent was paid out of pocket--people are using their own resources as opposed to some type of insurance coverage.

He proposed that under the leadership of this Committee, the Health and Human Services Finance Commission, the Department of Insurance, insurance industry representatives and consumer groups, such as the AARP, form a study group to develop a plan for Long Term Care Insurance in the State.

Senator Rubin expressed his appreciation for the good work.

Presentation to the Study Committee on Aging
September 20, 1984
Thomas E. Brown, Jr., Deputy Director
Planning & Assessment
South Carolina State Health & Human Services Finance Commission

Senator Rubin and members of the Study Committee on Aging thank you for the opportunity of addressing the Study Committee at this public hearing. I would like to report on the progress of the CLTC Project in Spartanburg and to address two other issues which I believe should be considered by the Study Committee during this next legislative year.

Before describing the progress since my last report to the committee, I would like to express my appreciation and the appreciation of the Long Term Care Policy Council for the strong support which the committee has given in the past to the Project. State FY 83-84 was the last year of the Community Long Term Care Research & Demonstration Project. The CLTC Project made the transition from the research and demonstration activity to the statewide system effective July 1, 1984. Intake for the Project ended as of March 31, 1984. During the 3 and 3/4's year research period, over 2,000 individuals were participants in the project, either as experimental clients or as control group participants. During the period April, May and June of 1984, the Project underwent a transition from its research activities to the statewide case management system. Over 1,500 individuals were discharged from the Project. Many of these clients were nursing home residents who had been participating in the project, as well as participants of the control group which was ineligible for project services. On July 1, 1984, 337 clients who have previously been experimental group participants were transferred to the statewide case management system. These individuals continue to receive home and community based services under the Section 1115 and Section 222 Research and Demonstration Authorities.

The external evaluation of the CLTC Project which was prepared by the Berkeley Planning Associates from Berkeley California has been completed in draft and has been forwarded to the Project staff for review and comment. The findings from this evaluation are consistent with the earlier findings reported by the project staff. BPA evaluated participants in the year one and year two cohorts who were studied for six months and twelve months of project participation. All of the individuals included in the study population were either skilled or intermediate level of care upon entering the project. The summary of the findings in this report are as follows:

a) Mortality rates both at twelve months and six months were not significantly different between the experimental and control groups. By twelve months, 26.3% of the experimental clients and 29.7% of the control participants had died. Most of these deaths had occurred during the first six months of participation.

b) participation in the CLTC Project had neither a positive nor negative impact in client functioning. Client functioning was measured by scales of activities of daily living and instrumental activities of daily living and a mental status questionnaire. Comparisons between the two groups at six and twelve months indicated that improvement and decline were virtually identical between the two groups.

c) regardless of the Project group membership, participants who entered nursing homes were more likely to be at risk in terms of level of impairment.

d) significantly fewer experimental clients entered nursing homes than did control participants. By the end of the first year, 35.5% of the experimental participants and 48.1% of the controlled participants had used Medicaid nursing home benefits. Based on these differences, the experimental clients were significantly less likely to enter nursing homes.

e) assignment to the experimental group rather than to the control group resulted on average in an additional 30 days of community living. Put another way, experimental clients spent an average of 8% more days in the community than members of the control group.

f) experimental clients had lower average monthly use and reimbursement from medicare for skilled nursing facilities but overall expenditures by Medicare did not differ between the groups.

g) the experimental group had significantly lower use of nursing homes and essentially equivalent total average monthly Medicaid payments as compared to the control group expenditures.

In summary, the Medicare and Medicaid cost and service utilization studies indicated that other than in the area of nursing home care, there were no statistically significant differences among the groups. Said another way, the CLTC system costs no more than the current system of care.

As the project was phased out, the state has sought waivers under Section 2176 for home and community-based services. I am appreciative of the support which the Study Committee gave to our request for approximately $3 million dollars in FY 84-85 to be used to match Federal Medicaid funds for this purpose. We are presently negotiating with the Health Care Financing Administration to obtain approval of the necessary waivers. We

have also involved Senator Thurmond and Representative Campbell in this process. I would appreciate the support from the Study Committee and would recommend that the committee authorize its chairman to contact Dr. Carolyne Davis, Administrator of the Health Care Financing Administration regarding the State's waiver application. Timely and favorable review and approval of this application is obviously a necessity.

The final report on the CLTC Project will be completed by the CLTC staff in early 1985. This report will be more comprehensive than Berkeley Planning Associate's evaluation. It will be made available to the Study Committee upon its completion.

An additional activity of the closeout of the CLTC Project will be a formal meeting in Spartanburg to discuss some of the Project's findings and to provide an opportunity to express appreciation to the many individuals and agencies which participated in making the CLTC Project a success. The date for the meeting has not been established. Members of the Study Committee will be invited to attend when a schedule has been set.

The second major item which I would like to address is the establishment of a mandatory pre-admission screening program for all individuals entering nursing homes. As you know, the Community Long Term Care Program currently operates such a system for all individuals requesting Medicaid funded nursing home care. I am suggesting that the Study Committee on Aging consider making this pre-screening program available to all individuals who are applying for nursing home admission irregardless of the source of payment.

Presently, approximately 25-30% referrals to the Community Long Term Care Program are for individuals who are presently nursing home residents and who are attempting to convert from private pay status to Medicaid. In many cases, these individuals have exhausted their own personal financial resources and the benefits of other programs, such as Medicare. In many occasions, these individuals have been determined to be ineligible for Medicaid sponsored nursing home care because their level of care needs did not meet those medical criteria established for the Medicaid Program. In these cases, there are considerable frustrations and anxieties on part of the patients and their families. A pre-screening program designed to assist individuals in remaining at home regardless of their source of payment might alleviate some of these unfortunate circumstances. Data which has recently been compiled on the Community Long Term Care Program indicate that for those individuals who were converting from private pay status to Medicaid the median length stay in the nursing home under private pay status was approximately 5.3 months. This means that within the study sample, 50% of those who convert to Medicaid did so within 5.3 months of admission. Further breakdown of these data indicates that 17% convert within 30 days, 35.6% convert within 90 days, 54% convert within 6

months and by the end of the first year of care in a facility, 70.5% convert to Medicaid. A mandatory pre-admission screening program for all the patients would benefit many of these individuals. Through this process, they will be able to identify their specific needs which could be met by home and community-based services as opposed to institutional care. Based on the findings that I have presented above, many of these individuals would be able to remain in their own homes for much longer periods of time prior to entering a nursing home. In some cases, nursing home admission may be unnecessary.

To implement a program of mandatory pre-admission screening, State legislation would be required. We have ample opportunity to review the experience of other states such as Georgia, Virginia, Illinois, Indiana, and others to determine the impact of such legislation. I am recommending that the Study Committee on Aging staff work with the staff of the State Health and Human Services Finance Commission to develop proposed legislation for consideration during the next legislative year.

The final topic which I would like to address is that of long term care insurance. We are all very aware of high level of long term care services which are provided by family and friends to individuals needing long term care. Estimates made by the General Accounting Office and other recent studies indicate that 60-70% of long term care needs are met by these sources. We also understand the great fiscal demands which have been placed on the state and federal governments to finance governmental programs providing long term care services. Many health care professionals and the elderly perceive the need for an adequate long term care insurance program which can be priced within the means of many moderate incomed elderly. A recent study by Mr. Mark Meiners entitled, "The State of the Art in Long Term Care Insurance", has been published by the National Center for Health Services Research. This study reviews the availability of long term care insurance and examines details of 16 policies. It also reviews coverage available through Medicare for home health and nursing home care. The study points out that private insurance covering long term nursing home care and home health services is available in some areas of the country. Generally however, home health insurance remains relatively undeveloped, as well as other policies which cover intermediate and custodial nursing home care. The paper suggests that there is a clear need for long term care insurance however, the availability continue to be limited. Further development will be dependent on improving consumer knowledge of their health insurance coverage (or lack of coverage) and the catastrophic expenses associated with long term care. It will also depend on an improve understanding of long term care and how to provide reasonable insurance for most risks.

So, given the fact that this type of insurance is not readily available, why should the State be interested in insurance and financing options for long term care? First of all, insurance

for long term care has potential to project many elder persons against the leading costs of catastrophic health expenditures. Specifically, in 1981 44% of nursing home expenditures were paid by private sources. Of these private expenditures, 99% were direct out-of-pocket expenditures. Secondly, insurance for long term care has the potential to greatly reduce or delay the number of persons becoming eligible for Medicaid. Earlier, I reported on the (Medicaid conversions) experience in South Carolina. In the 1977 study by the Congressional Budget Office, it was estimated that almost half of the people Medicaid paid for in nursing homes were not eligible upon entering but spent resources to becomes eligible for Medicaid.

I would like to recommend that the Study Committee on Aging take the lead with the State Health & Human Services Finance Commission, the Department of Insurance, insurance industry representatives, and consumer groups, such as the AARP, to develop a plan designed to encourage the development of long term care insurance in South Carolina. Some of the major issues which should be developed as part of the plan include:

1) a determination of the current availability of long term care insurance in the State;

2) what information is needed for insurance companies to develop policies which could be sold in the State;

3) what legislative issues and other state administrative actions i.e. change in regulations or philosophy, are necessary to create a positive environment for the development of additional long term care insurance coverage;

4) obtain public input on the need for this type insurance;

5) consideration of including these benefits in the state employees insurance program.

This plan should also identify the possible roles for the Study Committee and other departments of state government. Specifically, two major areas would be of major concern. First in the role of consumer protection, there will be an increased need for information to the public as well as regulation of rates and benefits. In the area of stimulating growth, state legislation and/or policies may require a amendment to encourage the development of this type of insurance. Specifically, consideration could be given to mandating coverage for state employees, initial subsidy of rates, working with employee and consumer groups, as well as insurance companies, to develop prototype policies.

In earlier testimony before this committee, I have reported that based on the 1980 census data, it appears that upwards of

80% of the state's elderly might be eligible for Medicaid in nursing homes if they were institutionalized over a long period of time. Out of this group, approximately 50% have income above the SSI level and below the Medicaid nursing home cap. This group of the elderly population would be the primary target for insurance such as I have just discussed. We all know that the current older population of the state increased by 50% between 1970 and 1980. State demographers have projected that this group would grow an additional 45% between 1980 and 1990. These data indicate a clear need for careful planning with regard to the issues surrounding long term care insurance.

I would like to express again my appreciation for the support and assistance which the committee has given to the Community Long Term Care Program. I look forward to the opportunity of working with the Study Committee in my new position as Deputy Director for Planning & Assessment for the State Health & Human Services Finance Commission to improve the services which are available to our elderly population.

Ms. Nancy L. Tintle, Acting Director
Community Long Term Care
S. C. State Health and Human Services
Finance Commission
P. O. Box 8206
Columbia, SC 29202

This presentation addressed the progress of the CLTC Statewide Program. The CLTC Service Management System has been implemented in all counties of the State. In 1983, 6,000 individuals were evaluated for long term care services. Out of this number 1,830 were eligible for their program because they could qualify for Medicaid in the community and were in need of skilled or intermediate care. Three hundred thirty-nine individuals--representing approximately 18 percent of the total eligible applicants-- were able to choose home care over institutionalization.

As reported to HCFA, the average Medicaid for applicants choosing nursing home care was $9,845 as compared to $1,422 for those who chose to receive care at home.

This FY with funding of 9.9 million dollars (2.6 million dollars in State funds) CLTC will be expanding the program to include new home and community-based services. About 8,000 Medicaid eligible long term care clients will receive home-based care.

In 1984 the CLTC management and planning staff have become part of the State Health and Human Services Finance Commission. The budget request of FY 85-86 includes an increase of $5,231,850 ($1,412,699 in State funds) in the service budget. This increase includes going to 12 months of operation (the FY 84-85 budget is based on a nine month implementation year) as well as a 4 percent increase in utilization due to growth in the eligible population. An additional $191,637 ($53,083 in State funds) is needed for their contract with DHEC for service management staff. The money includes funding for six clerical positions. Ms. Tintle asked for the Committee's support of this budget.

In closing, she expressed support for the Commission on Aging's request for funds to assist individuals who do not qualify for Medicaid and cannot affort community-based services. The legislation for Community Services for the Frail Elderly does not duplicate the services provided through the CLTC Program rather they will work together to provide a comprehensive service system for our elderly and impaired.

Presentation to the Study Committee on Aging
September 20, 1984
Nancy L. Tintle, Acting Director
Community Long Term Care
South Carolina State Health & Human Services Finance Commission

Senator Rubin and members of the Study Committee on Aging, I want to report on the progress of the Community Long Term Care Statewide Program. First I would like to take this opportunity to express my appreciation and that of the Long Term Care Policy Council and the Community Long Term Care Staff for the support which the Committee has given to our program in the past.

At the time of our last presentation, the Community Long Term Care Service Management System had been implemented in all counties of the State. All of our regional offices have had more than a full year of operation. In 1983, we evaluated 6,000 individuals attempting to access long term care services. Of this 6,000 approximately 1,830 were eligible for our program because they could both qualify for Medicaid in the community and were in need of skilled or intermediate care. Through implementation of a coordinated service plan of available Title XVIII, XIX, III and block grant services and with continued case management and monitoring, 339 of these individuals were able to choose home care over institutionalization. These 339 clients represent approximately 18% of the total eligible applicants. This percentage reflects almost exactly the anticipated service population expected based on the first years experience of the Community Long Term Care Research Project in Spartanburg.

As reported to the Federal Health Care Financing Administration, the average cost to Medicaid for the applicants who chose nursing home care was $9,845 as compared to $1,422 for those applicants who chose to receive care at home.

Since implementation of the Service Management System, we have had excellent cooperation from existing community service providers, nursing homes and hospitals toward reaching our goal.

This fiscal year with our funding of 9.9 million dollars (2.6 million in State funds) Community Long Term Care will be expanding the program to include the provision of new home and community based services. Approximately 8,000 Medicaid eligible long term care clients are projected to receive home based care. Many of these very ill clients will be eligible for Medicaid non-institutional and community based long term care services for the first time.

Planning is ongoing for implementation of these services. Any provider may contract with the Health & Human Services Finance Commission to provide any of the services included in the program. This is contingent only upon the providers ability to

meet certain quality standards and provide according to the specified scope of services.

Our FY 84-85 budget is based on a nine month implementation year. We hope to begin enrolling providers on schedule in late October pending Federal approval of our 2176 Waiver request.

This year the Community Long Term Care management and planning staff have become part of the State Health & Human Services Finance Commission. Since this move, and as the program becomes fully operational, the Long Term Care Policy Council will continue actively to have input into policy development in an advisory capacity to the Commission.

The Community Long Term Care Programs budget request for FY 85-86 includes an increase of $5,231,850 ($1,412,600 in State Funds) in the service budget. This increase reflects an annualization to a full 12 month of operation next year, as well as a 4% increase in utilization due to growth in the eligible population. We are also asking for an additional $191,637 ($53,083 in State Funds) for our contract with DHEC for Service Management staff. This money will include funding for six clerical positions needed to process and assure prior authorization of provider claims. This committees support for this budget is needed and will be most appreciated.

With the CLTC system fully operational, home and community based services will be available for Medicaid eligible individuals who need skilled or intermediate care. However, additional services are needed in our state for those individuals who do not qualify for Medicaid and who cannot afford community based services.

I want to express support for the Commission on Aging's request for funds to assist these individuals through legislation for community services for the frail elderly. This proposal does not duplicate the services provided through the Community Long Term Care program, as they are targeted to those who are not Medicaid eligible and/or to those who require services to remain in their homes, but are not quite disabled enough to require skilled or intermediate care. This proposed service system and the Community Long Term Care home and community based services system will work together well in providing a comprehensive service system for this state's elderly and impaired.

In closing, I would like to again express my appreciation for the excellent support our program has received from this committee in the past and would like to request favorable review and support for our budget request for fiscal year 85-86.

Thank you.

Dr. Kenneth N. Owens, President
S. C. Medical Association
458 Whiskey Road
Aiken, SC 29801

Dr. Owens urged the Committee to introduce a free standing bill next year to more adequately cover the subject of hospital restructuring than the legislation which amended the State Budget Bill for FY 84-85.

He further asked that the Committee look into alternatives to the rising health care costs without sacrificing the quality of patient care.

Other areas of concern were:

1. Passage of a Living Will law.

2. Reformation of the mental commitment laws. He urged that the Aging Committee monitor and get involved in the activities of the Mental Health and Mental Retardation Study Committee regarding this issue.

3. Referred to the age issue which was addressed in two bills last session (S-219 raised the age of exemption from jury duty from 65 to 70 years and H-2209 which eliminated mandatory retirement at age 72 for any employee or teacher who can demonstrate his mental and physical capabilities...). Dr. Owens feels that the age issue bears further study and said that "many people function very well both physically and mentally past 70 years...)"). Dr. Owens feels that these measures even though they saw no action in the General Assembly had merit, at least regarding the age issue.

Senator Rubin expressed his appreciation for the very good points.

Dr. Holler referred to the Death with Dignity legislation. He remarked that it seems the climate might be right for a positive, constructive law. He asked if the medial profession is prepared to submit a proposed act with the wording worked out from the standpoint of the doctor.

Dr. Owens is not sure that this is a subject that can be specifically outlined in law. Each situation warrants the in-depth participation of the family, physician, clergy and perhaps the legal profession in making specific determinations. It does not just pertain to the elderly, especially in his area of practice when an infant is delivered that is seriously compromised and has no specific possibility for quality of life. Under the present legal climate they are forced to make

determinations relative to prolonging life even when it is evident that it will never result in a viable functioning individual. "I am not sure that the profession is ready to address this problem and give you the kinds of answers that you would like to have to write a law that is equal in its application to all areas."

Senator Rubin commented that we had a well-written law; however, the strength of opposition was too great.

Dr. Owens added that they will give the Legislature whatever is necessary to come forward with a suitable law.

Thursday, September 20, 1984
Speech given by Dr. Kenneth N. Owens
For the Joint Legislative Committee
on Aging

LADIES AND GENTLEMAN OF THE COMMITTEE, MY NAME IS KENNETH N. OWENS, MD. I AM A PRACTICING OBSTETRICIAN, LIVING IN AIKEN, SOUTH CAROLINA, AND I CURRENTLY SERVE AS PRESIDENT OF THE SOUTH CAROLINA MEDICAL ASSOCIATION. I SPEAK BEFORE YOU TODAY ON BEHALF OF THAT ORGANIZATION. MY COMMENTS WILL BE BRIEF AND I WILL ADDRESS A FEW AREAS OF CONCERN.

AS PHYSICIANS, OUR ORGANIZATION IS CONCERNED ABOUT ANY SEGMENT OF THE POPULATION WITH A GREATER NEED FOR HEALTH CARE. THE ELDERLY, OF COURSE, OFTEN HAVE THIS GREATER NEED. THE COST OF CARE CONTINUES TO RISE AND THIS CAN MAKE IT DIFFICULT EVEN WHEN 80 PERCENT OF BILLS ARE SUPPOSED TO BE COVERED UNDER MEDICARE. THE SO-CALLED HOSPITAL REDISTRICTING BILL WAS SUPPORTED BY SCMA, VARIOUS MEMBERS OF THE AGING COMMITTEE, AND OTHER CONCERNED LEGISLATORS THIS PAST YEAR. THAT LEGISLATION, NOW PART OF THE LAW, WILL ALLOW ADDITIONAL HOSPITALS IN SOUTH CAROLINA TO ENGAGE IN REVENUE PRODUCING ACTIVITIES THAT MAY RESULT IN SIGNIFICANT COST SAVINGS.

WE WOULD URGE THAT A FREE STANDING BILL BE INTRODUCED THIS NEXT YEAR TO MORE ADEQUATELY COVER THE SUBJECT OF HOSPITAL RESTRUCTURING. THIS WOULD TREAT THE SUBJECT MATTER MORE ADEQUATELY THAN WAS DONE EARLIER THIS YEAR IN AMENDING THE STATE BUDGET BILL FOR FISCAL YEAR '84-85. WE FURTHER URGE THAT THIS COMMITTEE LOOK INTO OTHER ALTERNATIVES THAT COULD POSSIBLY LESSEN HEALTH CARE COST FACTORS WITHOUT SACRIFICING THE QUALITY OF PATIENT CARE.

FOR SEVERAL YEARS, MEMBERS OF THE AGING COMMITTEE WORKED TO PASS A "DEATH WITH DIGNITY" LAW. IN BOTH 1979-80 AND IN THE 1981-82 LEGISLATIVE SESSIONS SUCH A BILL PASSED THE STATE SENATE ONLY TO LANGUISH AND THEN DIE

ON THE HOUSE CALENDAR. SCMA, IN ADDITION TO LOBBYING FOR PASSAGE, TESTIFIED ON SEVERAL OCCASIONS BEFORE VARIOUS LEGISLATIVE BODIES. NOW THAT THE AGING COMMITTEE HAS WORKED FOR AND SEEN THE PASSAGE OF A BRAIN DEATH LAW, SCMA WOULD URGE THAT WE ALL GO BACK TO WORK UTILIZING THE SAME RESOURCES THAT HELPED TO PASS S-330 AND FACILITATE THE ENACTMENT OF A LIVING WILL TYPE LAW. SUCH LEGISLATION CAN BE OF GREAT BENEFIT TO THOSE PERSONS WITH A TERMINAL ILLNESS WHO CHOOSE TO EXECUTE A DOCUMENT SPECIFYING THE WAY THEY WISH TO BE TREATED.

AT ITS ANNUAL MEETING HELD EARLY THIS YEAR, THE SCMA HOUSE OF DELEGATES EXPRESSED A WISH THAT PHYSICIANS WORK TOWARD THE REFORMATION OF OUR MENTAL COMMITTMENT LAWS. RECENT NEWSPAPER COVERAGE IN SOUTH CAROLINA HAS POINTED OUT PROBLEMS IN OUR COMMITTMENT LAWS--ESPECIALLY THE FACT OF HOW ONE PHYSICIAN CAN SIGN THE PAPERS TO HAVE A PERSON COMMITTED TO A MENTAL INSTITUTION.

WHILE NO FIGURES ARE AVAILABLE TO US, IT WOULD SEEM THAT ELDERLY PERSONS COULD BE TAKEN ADVANTAGE OF MORE QUICKLY THAN THE POPULATION AT LARGE. UNSCRUPULOUS RELATIVES, FRIENDS, ETC., MAY FIND SUCCESS IN HAVING AN ELDERLY PERSON NEEDLESSLY PUT AWAY IN A MENTAL INSTITUTION FOR SELFISH REASONS.

THE JOINT LEGISLATIVE STUDY COMMITTEE ON MENTAL HEALTH AND MENTAL RETARDATION HAS CREATED A TASK FORCE TO STUDY THE MENTAL HEALTH COMMITMENT LAWS. DR. STEPHEN CRANE, A PSYCHIATRIST FROM CHARLESTON, SERVES AS A PHYSICIAN REPRESENTATIVE TO THAT BODY. WE WOULD URGE THAT THE AGING COMMITTEE, IF NOT ALREADY INVOLVED WITH THIS UNDERTAKING OF THE MHMR COMMITTEE, MONITOR THE ACTIVITIES UNDERWAY AND UNDERTAKE INVOLVEMENT IF DEEMED NECESSARY AND APPROPRIATE.

LEGISLATION WAS INTRODUCED IN 1983 THAT WOULD HAVE RAISED THE AGE OF EXEMPTION FROM JURY DUTY FROM 65 YEARS TO 70 YEARS. THE PARTICULAR BILL

INVOLVED, S-219, INCLUDED OTHER MATTER WHICH DELETED THE EXEMPTIONS GIVEN TO M.D.'S AND CERTAIN OTHER HEALTH CARE PROVIDERS. BECAUSE OF THE ADDITIONAL LANGUAGE ON EXEMPTIONS OF HEALTH CARE PROVIDERS, THE BILL DIED ON THE HOUSE CALENDAR.

WE FEEL THAT THIS LEGISLATION PROBABLY HAS MERIT AT LEAST AS REGARDS THE AGE ISSUE. MANY PEOPLE FUNCTION VERY WELL BOTH PHYSICALLY AND MENTALLY PAST 70 YEARS OF AGE AND CERTAINLY WELL BEYOND AGE 65. WHILE IT APPEARS THAT THIS COMMITTEE WAS NOT INSTRUMENTAL IN THE INTRODUCTION OF S-219 THIS PAST TWO-YEAR SESSION, WE DO FEEL THE PROPER AGE FOR JURY SERVICE MAY BEAR SOME SCRUTINY.

ALONG THIS SAME VEIN, WE MAKE NOTE OF H-2298, WHICH WAS INTRODUCED IN EARLY 1983 BUT NEVER SAW FURTHER ACTION IN THE LEGISLATURE. IT WOULD HAVE ELIMINATED MANDATORY RETIREMENT AT AGE 72 FOR ANY EMPLOYEE OR TEACHER WHO COULD DEMONSTRATE TO HIS EMPLOYER AND THE STATE BUDGET AND CONTROL BOARD THAT THAT PERSON IS MENTALLY AND PHYSICALLY CAPABLE OF PERFORMING HIS DUTIES. THIS LEGISLATION, OF COURSE, DEALT ONLY WITH STATE EMPLOYEES AND NOT THE POPULATION AT LARGE. FOR THE SAME REASONS GIVEN ABOVE, PERHAPS THIS IDEA TOO BEARS FURTHER STUDY.

MR. CHAIRMAN, OTHER MEMBERS OF THE COMMITTEE, THESE ARE OUR PREPARED REMARKS. THANK YOU FOR THE OPPORTUNITY OF APPEARING BEFORE YOU TODAY. I WILL BE HAPPY TO ANSWER ANY QUESTIONS PUT FORTH.

Judy Fickling, Exec. Director
S. C. Nurses' Association
1821 Gadsden Street
Columbia, SC 29201

Awareness of the increasing costs in health care and institutionalization have prompted the Nurses' Association to publicly address these problems.

Two Resolutions will be introduced that support home health care services and educational opportunities for nurses who provide care for the State's older citizens.

Since nurses have more frequent and prolonged contact with families and clients, they provide continuity of care and a holistic approach to the needs of older persons and their families.

The more than 13,000 registered nurses of the SCNA offer their support, knowledge and expertise to the elderly and their families so they can receive humane and cost effective health care.

South Carolina Nurses' Association

1821 GADSDEN STREET
COLUMBIA, SOUTH CAROLINA 29201
TELEPHONE 252-4781

TO: The Joint Legislative Study Committee on Aging

DATE: Thursday, September 20, 1984

PLACE: Room 101/109 Blatt Building
Columbia, South Carolina

Good afternoon, I am Judy Fickling, Executive Director of the South Carolina Nurses' Association, the professional association for registered nurses.

The South Carolina Nurses' Association is aware of the increasing cost of medical care and institutionalization, the increase in the percentage of the population over 65 years of age, and the increasing incidence of chronic diseases among this age group, as well as the relationships among this phenomena. These concerns have prompted the SCNA to publicly address these problems and to support legislation that would provide alternatives to institutionalization through community home health services. Home health care services provide a viable alternative to institutionalization by maximizing self-sufficiency, independent living quality of life, and reducing medical and institutionalization costs.

At SCNA's House of Delegates meeting, October 26, 1984, two resolutions will be introduced that support home health care services and educational opportunities for nurses who provide nursing care for the State's older adults. The SCNA also supports legislation to control medical and institutional health care costs through activities of this Special Interest Group in Gerontology working in collaboration with other groups and agencies who are attempting to contain health care costs.

We want to take this opportunity today to remind you of the nurse's role in preventing illness, promoting wellness, and assisting families and individuals to maintain a healthy lifestyle. Many times, the registered professional nurse is the only accessible health care provider, because she will make home visits. Individuals and families depend on the nurse for health care knowledge, judgment, counseling, and the coordination of interventions by other practitioners, such as physicians, pharmacists, and social workers.

Nurses are in the mainstream of health care delivery. Nurses have more frequent and prolonged contact with families and clients, and are, therefore, knowledgeable about total health care needs, transcending a speciality or medical focus. Nurses provide continuity of care and a holistic approach to the needs of older adults and their families.

Nursing knowlege and practice have at times been ignored or overlooked in the development of health care policy, despite the fact that nurses may have a better appreciation and understanding of the needs and problems of the older adults and their families than any other group of health care professionals.

The SCNA, the professional organization of more than 13,000 registered nurses practicing in South Carolina offer their support, knowledge, and expertise to older adults and their families in an effort to obtain health care policy that is equitable, humane, and cost effective.

Dr. James B. Ebersole, Chairman
Department of Family Medicine
USC School of Medicine

The Department of Family Medicine is taking initiatives to provide for the health care needs of the growing elderly population. It is projected that over 30 percent of the health care dollars will be spent on those over 65 who will make up 20 percent of the total population in this county in the year 2000.

Physicians of the future must be trained in the care of the elderly and medical schools must adjust their curricula so they can be in the forefront of geriatric care. At this point, however, none of their departmental curricula or training facilities meet these educational needs.

Geriatrics will be the name of the game for graduating medical students in the future. Innovative health care delivery systems must be developed, plans must be made for expanding facilities for day care and for improving the quality of care in nursing homes, and above all improved preventive care must be made available to recognize and treat correctable conditions.

The Department of Family Medicine believes that family doctors may be in the best position to help solve the above-mentioned needs and problems since they provide the continuity of care--from the home to the hospital to the extended care facility.

For several years now the Department of Family Medicine has offered seminars in geriatrics to students in their third-year clerkship. These students also work with patients who are enrolled in the Family Practice Center and Richland Memorial Hospital. Starting this fall, a fourth year elective in geriatrics will be offered.

Under a grant from the Columbia Council on Aging, the Center is providing health screening examinations for 500 elderly who are presently not part of any health care system. The Department further has contracted with three local nursing homes for medical and psychological services provided by the Family medicine faculty. Approximately 400 intermediate and skilled care beds provide ample numbers of geriatric patients for teaching program for both students and residents.

Mention was made of a Federal Training Grant of $593,000 for three years (starting in July 1984) to supply personnel and equipment needed for the training of students and residents in geriatrics and wellness.

Richland Memorial Hospital established an Ad Hoc Geriatric Committee which studied the needs of the elderly in the community and made several proposals for a multidisciplinary approach to meet these needs.

In closing Dr. Ebersole said that these are some of the ways in which the Department of Family Medicine believes that medical schools can prepare students for the aging population.

Senator Rubin appreciated the encouraging report which showed that the School of Medicine is giving increased emphasis on geriatric training.

NOTE: (Dr. Ebersole made available a videotape which is on file with the Committee on Aging. Text of the videotape is on page 101 of this transcript).

GERIATRICS

PREPARING NOW FOR FUTURE CHALLENGE

The Department of Family Medicine is taking bold initiatives to provide for the health care needs of the elderly. As this segment of our population grows, it creates a possible crisis in health care delivery in the near future and we must be prepared to meet the challenge. Senior citizens will soon constitute a third of the voting population and they will be able to wield great influence on many issues, including their own health care. It is projected that over 30% of the health care dollar will be spent on those over 65, who in the year 2000 will make up 20% of the total population of this country.

With this realization, better education of medical students in the care of the elderly becomes essential. A knowledge of the special problems and needs of the elderly is a requisite for students as well as for residents in all fields of training, for it is unlikely that any single specialty group will be identified to provide the comprehensive care that they require. They must know about the differences in physiology, in drug dosages, in nutritional needs, and in the unusual manner in which common diseases frequently present in the elderly. Physicians of the future must also be better trained in working with paramedical people to help curb costs and to deliver team care that is more comprehensive than any one individual can provide.

What should be done?

It is apparent that medical schools must make changes in their curricula if they are to take their place in the forefront of geriatric care. Other health care providers, recognizing the need, are already making inroads into this area. If the health care provided to the elderly by physicians is not imaginative and adequate, critical decisions will not be made by the medical profession but by other groups, including governmental agencies.

At this point, none of our departmental curricula or training facilities ideally meet these educational needs. We must experiment with various models for teaching geriatrics in order to achieve the goal of graduating medical students properly trained in geriatric care, for Geriatrics will be the name of the game in their future. Innovative health care delivery systems must be developed to deal with the multiple medical and psychosocial problems characteristic of the elderly, and plans must be made for expanding facilities for day care and for improving the quality of care provided in nursing homes. Effective delivery systems for ambulatory care to reduce costs, and improved preventive care to reduce the multiplicity of problems, must be developed. We must be on the alert to recognize and treat correctable conditions, and to maximize the benefits of rehabilitation.

How can it be done?

We believe that family physicians may be in the best position to assist in the solution of some of these problems, functioning as coordinators of effort as they are accustomed to functioning as coordinators of health care for their patients. Family physicians provide the continuity of care required by the elderly and their families, over a span of years and any site --- from the home to the hospital to the extended care facility. Because they are the only specialists specifically trained in office practice and in patient management in the home, family physicians are also in a position to teach the concepts of cost containment, another cardinal consideration in medical care in the future.

What is being done now?

For several years the Department of Family Medicine has give a series of seminars in Geriatrics to students in the third year clerkship. The topics include:

Elderly Patients and Their Problems
The Confused Elderly Patient
Drugs and the Elderly
Falls, Osteoporosis, and Estrogens
The Psychology of Aging
Common Medical Problems in Nursing Home Care
Geriatric Case Presentations

Third year students also work with elderly patients who are enrolled in the Family Practice Center and when they are admitted to Richland Memorial Hospital, and they will make rounds on nursing home patients cared for by members of the Department. A fourth year elective in Geriatrics, in which students will participate in the care of the elderly in all of these settings for a full month, will be offered, starting this fall.

Under a grant from the Columbia Council on Aging, the Center is providing health screening examinations for 500 elderly people who are presently not a part of any health care system. These examinations include a health status inventory, physical examination, and health counseling.

The Department has also contracted with three local nursing --- Brian Center of Columbia, Brian Center of Forest Hills, and the Episcopal Home (Still Hopes)---for medical and psychological services provided by the Family Medicine faculty. These four hundred or more intermediate and skilled care beds provide ample numbers of geriatric patients for an extensive teaching program for both students and residents, and hospitalized patients from these facilities increase our opportunity to deal with the more severe medical and social problems confronting the elderly.

Family Practice residents also provide some night and weekend medical coverage for the elderly who reside at W.C. Tucker Center, a long-term facility under the State Department of Mental Health. A one-month rotation in Geriatrics for second year Family Practice residents began this July. These residents, under faculty supervision, provide medical care for our elderly patients at home, in the Family Practice Center, and in nursing homes. From this experience, each resident will be assigned several patients to be followed for the remainder of their residency training, thus providing training in continuity of care in the ambulatory setting.

These various programs offer an opportunity for clinical research into the health care needs of the elderly, with the aim of developing innovative medical and economic solutions to their health care problems.

The Department has received a federal training grant of $593,000 for three years, which began in July 1984 to supply personnel and equipment needed to enhance the training of residents and students in Geriatrics and Wellness. Included in the personnel funded by this grant are a geriatrician, a patient educator and a family nurse practitioner.

The grant program also includes large elements of home health care, which we believe offers much to the future care of the elderly. It is more cost effective than institutional care, and encourages the elderly to remain with their families or living independently for as long as possible. Under the grant, residents and students will be trained in the vanishing art of home visits under the tutelage of the Family Practice faculty and a Geriatrics nurse practitioner who will act as coordinator of the home health program.

Recently, Richland Memorial Hospital established an ad hoc Geriatric Committee which includes two members of the Family Medicine faculty and which studied the needs of the elderly in the community and made several proposals to meet those needs. These plans include an in-house Geriatric Consultation Team, Home Health and Sociomedical Services, a comprehensive Outpatient Rehabilitation Facility, Institutional Services (including nursing home services), and a Houseing Service (a range of options for the 95% of the elderly who are not in institutions). Our department will be involved in this multidisciplinary approach, which attempts to meet the hospital's responsibility to the elderly in this community.

These are some of the ways in which we believe that medical schools can prepare students to meet the challenge of our aging popultion. If they are well trained in Geriatrics, physicians will find the care of the elderly to be a rewarding experience, whatever their field of practice.

Recently the University of South Carolina School of Medicine Clinical Advisory Committee, composed of the Department Chairman who are advisory to the Dean, discussed the importance of this new medical school developing an "area of excellence" which would focus national attention on our activities here. Strong interest was expressed in identifying Gerontology as this area of special focus. Already the basic science departments are involved in research on aging and our clinical departments are orienting health care delivery toward the elderly. The Dean has expressed interest and enthusiasm in this concept.

Considerable interest in health care for the elderly has been generated at Richland Memorial Hospital, University of South Carolina School of Medicine, and specifically in the Department of Family Medicine. Significant progress has been made to date and the prospects for the future are exciting.

James B. Ebersole, M. D.
Chairman, Department of Family Medicine
University of South Carolina School of Medicine

THE TEXT OF THE VIDEOTAPE

What do you see, nurse?
What do you see?
What are you thinking when you look at me?
A crabby old woman, not very wise,
Uncertain of habit, with faraway eyes,
Who dribbles her food and makes no reply
When you say in a loud voice, "I do wish you'd try."
Who seems not to notice the things that you do
And forever is losing a stocking or shoe,
Who, unresisting or not, lets you do as you will,
With bathing and feeding the long day to fill.
Is that what you're thinking?
Is that what you see?
Then open your eyes, nurse,
You're not looking at me!

I'll tell you who I am, as I sit here so still,
As I rise at your bidding and eat at your will.
I'm a small child of ten with a father and mother,
Brothers and sisters who love one another.
A young girl of sixteen with wings on her feet,
Dreaming that soon now a lover she'll meet.
A bride soon at twenty, my heart gives a leap,
Remembering the vows I promised to keep.
At twenty-five builds a secure happy home.
A woman of forty, my young now all grown,
But my man stays beside me to see I don't mourn.
At fifty, once more babies play at my knee.
Again, we know children, my loved one and me.

Dark days are upon me; my husband is dead.
I look to the future, I shudder with dread.
For my young are all busy rearing young of their own,
And I think of the years and the love I have known.
Now I'm an old woman, and Nature is cruel.
Tis her jest to make Old Age look like a fool.
The body, it crumbles; grace and vigor depart.
There's now stone where I once had a heart,
But inside this old carcass a young girl still dwells,
And now and again my poor, battered heart swells.
I remember the joys, I remember the pain,
And I'm loving and living life all over again.
I think of the years, all too few, gone too fast,
And accept the stark fact that nothing can last.
So open your eyes, nurse, open and see,
Not a crabby old woman,
Look closer, see me!

Ms. Virginia Campbell, Nurse Counselor
Lexington Mental Health Center
322-1/2 S. Lake Dr.
Lexington, SC 29072

Ms. Campbell is the liaison between the community, the hospital and the community care home, which is a boarding home. Most of the boarding homes she deals with are licensed by the Department of Mental Health. Ms. Campbell does assessments from general hospitals, family doctors, DSS, Mental Health, anybody who has a person they like to place into a community care home. While doing the assessments, she found many among the elderly who did not qualify for a community care home nor for a skilled nursing care home. In other words, there is no place for them to go. The family cannot keep them any longer, so they are placed in boarding homes with misgivings. However, Ms. Campbell is uncomfortable having them placed in boarding homes as some have medical problems that need to be followed up. "About 30-40 percent of the elderly fall into this group--they need care that we are not providing".

Senator Rubin wondered if the adult day care center could provide for them.

Ms. Campbell explained that this group of people need a place they can afford financially and, above all, where they can stay. Some of these people qualify medically but not financially to go into skilled care homes. As a last resort, they can be put into Crafts-Farrow, but if they do not have a mental condition, they should not be put there. However, in the end they are put into Crafts-Farrow because "we still have some family doctors that can place people into a mental institution without having to go through our centers."

Senator Rubin commented that this has long been known on both sides--it is a refuge.

Ms. Campbell screened 83 senior citizens this year. Thirty-two out of these have no place to go; she does not know what to do with them. "This is something we need now, not five years from now, It will be needed more and more as the elderly population increases."

Senator Rubin thanked Ms. Campbell for directing the Committee's attention to this matter.

Ms. Campbell added that these are just the senior citizens. If they have mental conditions, then of course there is Crafts-Farrow.

Ms. Edna Holtzclaw, Coordinator
Special Services
Chesterfield Mental Health Center
P. O. Box 471
Chesterfield, SC

This testimony was a follow up to what Ms. Campbell and Dr. Hilda Ross had already said. Ms. Holtzclaw begged the Committee for the development of a level of residential care between the boarding home and the intermediate care nursing facility.

She screens patients at State Hospital and Crafts-Farrow from their area (Chesterfield, Marlboro and Dillon counties) for potential placement in community care homes or other alternate living arrangements. She, too, found that many of these patients were "unplaceable" mainly because they did not qualify for an intermediate care nursing facility but needed more care than a licensed boarding home can provide.

Furthermore, boarding home operators are reluctant to accept patients who require more care than the more "desirable" patients as the boarding homes receive the same reimbursement rate. Ms. Holtzclaw recommended that the Study Committee on Aging consider a system for funding reimbursement of care at a level between boarding home and intermediate care. In addition, the staff-patient ratio needs to be at a minimum 1:7 (one staff members to seven residents); presently it is 1:10. In order to enable the home to employ adequate staff for the new staff-patient ratio, reimbursement needs to be at $28/day whereas now it is at $14/day.

Senator Rubin agreed with the points in this presentation. However, the Budget and Control Board announced that it will take most of the money just to carry forward what is built in. They won't be able to have innovations this year. "These are the things that leave me with a heavy heart when I leave these meetings."

I want to ask the committee to recommend the development of a level of residential care between Boarding Home and an Intermediate Care Nursing facility. My name is Edna Holtzclaw. I am director of the Chesterfield County Office at Tri-County Mental Health Center. For the past 15 years, as an employee of the Department of Mental Health, I have worked primarily with the chronically mentally ill. Not all of these people are elderly but a majority of the under 55 year olds do have many of the same needs as our older chronically mentally ill population.

For the past year and a half I have been very involved in screening the patients at the State Hospital and Crafts-Farrow for our catchment area - Chesterfield, Marlboro, and Dillon Counties - for potential placement in Community Care Homes or other alternate living arrangements. We have been highly successful in placing 23 of these clients in our local boarding homes. To do this, our Center developed a highly structured living skills program on the premises of a local boarding home, Cheraw Manor, owned by Dr. Winston Godwin. With his cooperation, we have Center staff there 5 days a week for four hours each day. During this time period various skills are taught to each client based on individualized assessment of needs related to daily living. This includes bathing, dressing, grooming, taking care of personal belongings, communication skills, safety, leisure skills, educational and vocational needs. We designed the program to teach and/or enhance those skills needed to enable the clients to make an easier transition to a less restricted living situation.

As we gained experience in working with our folks, we found that some of the residents required daily assistance in bathing, shaving, and dressing.

Some of these people perhaps had the skills but due to their long stay in an institution they have lost these skills for whatever reason. Our staff has spent much time with these clients individually and in a group teaching these basic skills. We found that many are unable to follow through on their own initiative in accomplishing these tasks.

Because they require so much assistance, much time is expended by the Boarding home staff in the care for these individuals, especially in the morning and at bedtime. This, in turn, causes the boarding home operators, naturally, to be reluctant to accept patients from the institution who function at this low level in the area of living skills. These patients require more care than the more "desirable" resident but the home receives the same reimbursement rate.

In screening and assessing patients at the institutions, I found that so many of them were "unplaceable" because we, the community, do not have homes capable of providing the staffing pattern necessary to care for these patients. The patients screened did not qualify, nor need, an Intermediate Care Nursing facility but did require more care than that provided in a presently licensed boarding home.

I would like to recommend the Study Committee to consider mechanisms for funding reimbursement of care as a level between boarding home and Intermediate Care.

The staff-patient ratio needs to be placed at a minimum of one staff member per seven residents during peak hours (6 AM - 2 PM; 4:30 PM - 9:30 PM). Presently, a boarding home is required to have one staff per ten residents.

Reimbursement would need to be at least $28.00 per day to enable the home to employ adequate staff for the above staff patient ratio. Presently the home is reimbursed at $14.00 per day.

I currently serve on the State Plan Advisory Council of the Department of Mental Health and have become much more aware of the many problems facing not only this agency but also other agencies in dealing with the many people in our state needing our assistance and our concern.

As a child of an 82 year old mother who lives with me, I am concerned that when I am no longer able to give her the type care she needs, that she can receive adequate care in a home near me. And, that she will be able to receive this care and still maintain her dignity. She is a great lady.

As an adult taxpayer, I am concerned that she, as well as my 83 year old Aunt Vera, who lives alone and has no children, will be able to have this dignified care at a cost that does not break my bank account.

And as a mother, whose only child - a son - said he would put me in a home when I got old - "How old?" I asked - "50" he said. I am concerned about my care when he can no longer care for me.

These are concerns of all of us. Thank you for the priviledge of being able to say this out loud. I appreciate your listening as I climbed upon my soap box.

Rev. William F. Pentis, Member
Aging and Mental Health Boards
P. O. Box 11586
Rock Hill, SC 2973;

Father Pentis presented to the Committee a Resolution in favor of the passage of S-704, the Uniform Probate Code, and H-3417, the Community Services Legislation. (Copy of the Resolution and attachments of names of the members of the Catawba Area Agency on Aging's Advisory Committee are on file in the Study Committee on Aging).

His main reason for appearing before the Committee was to not forget the individual's varying needs when drawing up legislation and programs to coordinate services and make them more cost efficient.

"We are individuals and have individual needs that vary; do not make of us numbers on a computer."

Senator Rubin thanked Father Pentis and told him that he was a caring person.

Testimony given by William F. Pentis to the South Carolina Study Committee on Aging at its public hearing on 9/20/84.

Senator Rubin and members of the Study Committee: Thank you for this time to appear before you.

On behalf of the Catawba Area Agency on Aging's Advisory Committee I am presenting you with our resolution in favor of the passage of S704-H3417 - The Uniform Probate Code and H2364 - The Community Services Legislation. We feel that the Uniform Probate Code is long overdue and needs to be passed this year. As more people stay out of nursing homes or come out of them, more in-home services must be provided through the aging network, and thus more funds for these programs. We are experiencing the push to get elderly patients out of hospitals without provision for proper care at home. Thus the need for expanded in-home services to survive. Attached to our resolution are the names and addresses of our members voting on it.

My main reason for taking the time and personal expense to appear before you is to speak for the varied needs of the individual citizen when legislation and programs are considered by you. Supposed economy draws attention and favor, but if the end product is poor service, or worse, the ignoring of individual needs because "it is not in the contract", then our service of the aging is worse, not better. Efficiency is great if it is coupled with care for individual needs. In working with the aging, it is impossible to spell out how to love and care for each person with individual needs. If those who are serving are only doing a "job" to earn money, then they can very well be more concerned about the paper work of record keeping than the client. A case in point is the Project Managment Agency that was mandated by the General Assembly, financed by it, and tried out in York County. Its aim to coordinate services and make them more cost efficient was great. It did consume a vast amount of valuable time of agency directors and staff (and State's money) to do its work. Some good came from it, but I am afraid the care of the individual needs have suffered. It seems that the personal care tends to become impersonal when you have a large central system like the transportation system left by PMA. There is no way in the world one can know the day to day needs of the aging; one day a person may be able to walk fine by himself or herself, the next day the same person may need assistance all the way into the house. I think caring persons within an organization are more able to be flexible and loving enough to care for changing needs than some super service. Let us not for the sake of record keeping and supposed efficiency (money saving) say to the aging, "I really don't care about you, but about the mark on this record". We are individuals and have individual needs that vary; do not make of us numbers on a computer. Thank you!

Winston Thomas, Program and Information
Coordinator
Governor's Office
Division of Health and Human Services
Brown Building
Columbia, SC 2920Mr.

Mr. Thomas gave a progress report of the initial efforts of the Governor's Resource Panel on the Elderly and current efforts of the Governor's Implementation Committee on Recommendations for the Elderly.

In March of 1983, the Resource Panel presented Governor Riley with a report entitled "Preparing for a New Generation of Older South Carolinians." This report contains 187 recommendations for an organized system of service delivery to older citizens. To ensure smooth transition of these recommendations, Governor Riley appointed the Implementation Committee on Recommendations for the Elderly.

The Implementation Committee established time frames for Phase I of the implementation process. They divided the 187 recommendations into three categories: (1) Those that could be accomplished with little or no additional funding and could be initiated within an agency; (2) those that would require legislative or executive action; and (3) recommendations for information, planning and policy development.

The next step was to identify agencies and organizations that would be directly involved in the Implementation Process and make the necessary assignments of recommendations. Thirty-six implementing agencies were identified involving the public and private sector.

On April 27, 1984, Governor Riley addressed the Annual Statewide Aging Network Conference. This address was regarded as the official kickoff for the Implementation Process.

Phase II of the Implementation Process is currently underway which addresses the critical interaction between the various subcommittee and the agency contacts. The direction of the total Implementation Process will be clearly defined during Phase II. Agencies will initiate action on recommendations that will not require legislative or executive action right now. Several recommendations have already been implemented and many more in the implementing stages.

In closing, Mr. Thomas said that many of the concerns expressed at this Hearing have in some form been addressed by the Governor's Resource Panel on the Elderly Report and will in some form be acted upon by the Governor's Implementation Committee on Recommendations for the Elderly. The Governor's Implementation Committee is committed to fulfilling its responsibility with the continued encouragement by the Governor, the continued work by the Study Committee on Aging, the Commission on Aging and the aging network. The success of all this is very imminent and everybody involved is dedicated to preserve what is a valuable natural resource, South Carolina's older citizens.

Senator Rubin said that the Committee will be glad to work on all these matters.

Study Committee on Aging Public Hearing
September 20, 1984

Presentation by
Winston Thomas, Governor's Office
Division of Health and Human Services

Re: Progress Report - The Governor's Implementation Committee on Recommendations for the Elderly

Senator Rubin, and members of the Study Committee on Aging, my purpose for making a presentation today is to inform the Study Committee on Aging and the general public about the initial efforts of the Governor's Resource Panel on the Elderly and the current efforts of the Governor's Implementation Committee on Recommendations for the Elderly.

Some of you present here today are aware of the fact that in 1982, Governor Riley established by Executive Order the Governor's Resource Panel on the Elderly for the purpose of determining the current impact of services for the elderly and to assess the present and future needs of this segment of our population. The Resource Panel members were charged to develop goals and to make recommendations for appropriate changes through the governmental process as well as the private sector.

In March of 1983, the Resource Panel presented Governor Riley with a report titled "Preparing for a New Generation of Older South Carolinians."

The Resource Panel Report contains 187 recommendations designed to create an organized system of service delivery for older citizens when implemented.

To accomplish the objectives of a report, a strategy of planned change needs to be initiated. Through a process of social planning and public policy making, a report is transformed from concept to reality, from theory to practice, from symbol to substance.

In order to ensure a smooth transition from the printed word to action, Governor Riley appointed the Governor's Implementation Committee on Recommendations for the Elderly. Professor Len Tartaglia, College of Social Work, University of South Carolina, was appointed Chairman, and M. L. Meadors, Chairman of the South Carolina Commission on Aging was appointed Vice-Chairman.

The first order of business for the Implementation Committee was to establish time frames for Phase I of the Implementation Process and to develop a strategy for dealing with the 187 recommendations contained in the Resource Panel Report.

The Implementation Committee divided the 187 recommendations into three categories: (1) Those recommendations that could be effected with little or no additional funding, and could be initiated within an agency by re-ordering priorities, or increased emphasis on existing services; (2) Those recommendations requiring legislative or executive action, and funding with long-range implications; (3) Recommendations for information, planning, and policy development.

The next step was to identify agencies and organizations that would be directly involved in the Implementation Process, and make the necessary assignments of recommendations.

Initially 36 implementing agencies were identified involving the public and private sectors.

On January 12, 1984, the Governor's Implementation Committee on Recommendations for the Elderly met to discuss the recommendations and to confirm strategy for Phase I of the Implementation Process.

On February 29, 1984, Governor Richard W. Riley sent a letter to the agencies and organizations identified in the Resource Panel's report explaining the Implementation Process and soliciting their support. Under the aforementioned letter, the agencies also received a package of information detailing the Implementation Process and their roles.

The agencies were asked to name an agency contact to work with the Governor's Implementation Committee and to respond to the recommendations. assigned to their agency.

Upon completion, the agencies forwarded their responses on assigned recommendations to staff of the Governor's Office, Division of Health and Human Services for compilation and analysis.

On April 19, 1984, all agency contacts were briefed concerning the Implementation Process and their roles.

On April 27, 1984, at the Columbia Marriott Hotel, Governor Riley addressed the Annual Statewide Aging Network Conference. His address was regarded as the official kickoff for the Implementation Process.

After receiving agency responses to their assigned recommendations, a profile was completed on each recommendation returned. The profile consisted of a summary of data from agency responses and staff comments.

Profiles have been completed on 127 recommendations as of this report. There are 17 general statement recommendations which were not assigned to any agency because they made general overall statements about the entire service delivery system. Currently there are 43 recommendations that have to be profiled.

- PHASE II -

Phase II of the Implementation Process is currently underway. This is a very important stage of the process because it features the critical interaction between the various subcommittees and the agency contacts. Any problems or concerns with recommendations will be dealt with in the numerous meetings that will be taking place.

The direction of the total Implementation Process will be clearly defined during Phase II. Recommendations will be re-grouped, combined, eliminated and rewritten for clarity.

Agencies will initiate action on recommendations that will not require legislative or executive action at this point. A tracking and monitoring system will be developed during Phase II, which will enable the Implementation Committee to keep track of progress or lack of progress concerning any particular recommendation.

Implementing entities have begun urging support throughout their organizations for the implementation of their assigned recommendations. To date, several recommendations have been totally implemented, and many more are in the implementing stages.

A public awareness strategy has been developed to not only create more agency awareness but to inform the general public as well.

Many of the concerns expressed today have in some form been addressed by the Governor's Resource Panel on the Elderly Report, and will in some form be acted upon by the Governor's Implementation Committee on Recommendations for the Elderly.

The Governor's Implementation Committee is aware of the magnitude and complexity of its task. It is committed to fulfilling its responsibility—

encouraged by the leadership of the Governor and the goal to preserve a valuable natural resource, South Carolina's older citizens.

Ms. Mary Frances Payton, Project Administrator
AFDC Homemaker/Home Health Aide Demonstration
Project
Department of Social Services
P. O. Box 1520
Columbia, SC 29202-9988

Ms. Payton expressed her appreciation for having been asked to appear at this Hearing today. "We want you to be aware of this most wonderful project we have been implementing in South Carolina in the last year and one-half."

The Project was authorized by the Omnibus Reconciliation Bill of 1980. It is presently being implemented by seven states; South Carolina is the only Southern state. The parameters of this Research Project are outlined by this legislation and further guidelines from HCFA. It is Medicaid funded, 90 percent Federal and 10 percent State. About one-half of the State match is paid from the savings resulting from the welfare savings of the AFDC recipients who go to work and are terminated from the welfare rolls.

There are two components involved in this Project:

1. AFDC women who have been on welfare up to 90 days and have not been employed are selected and trained. Most of these women are 3rd and 4th welfare generation and it is hoped that the welfare cycle can be broken. After they have been selected and received training at the local TECs throughout the State for four weeks in intensive home health aide services, they are subcontracted out to a public or private, nonprofit agency. They work for them up to 12 months; at that time the main concern is to get these people completely off the welfare rolls and from subsidized employment into unsubsidized employment and on their own.

2. The second component is the homemaker, home health aide service to the elderly. This service is available without regard to income, you do not have to be Medicaid/Medicare eligible. It is provided to anyone 18 years of age or older who is handicapped, disabled and, of course, the elderly. This service is presently offered in 17 counties and is continuing to expand. They have trained 355 AFDC mothers who are working in these 17 counties and are currently serving 690 elderly handicapped persons.

The statistics show that the majority of the people they are serving are females, equally black and white, who are

between the ages of 75 and 84 with less than $500/month income and are on Medicare. This works well with the Community Long Term Care Project which services Medicaid people and this Project services Medicare people. "This is where the unmet need is for these services in the State." Referrals of the elderly and handicapped come from all agencies, to name a few: Long Term Care, Councils on Aging, home health nurses, Mental Health, Mental Retardation, doctors, discharge workers at hospitals, social workers at nursing homes.

The Project is being evaluated by an independent evaluation firm in all the seven states and the findings will be analyzed. If the Project seems to be successful, they hope it will become a blueprint for a program that will look at the two most serious costly social problems existing today: welfare dependency and unnecessary institutionalization.

They have asked the State for only $268,000 match this year. The Project is very cost effective as half of the State match is coming from the welfare savings from the women who go off the welfare rolls and food stamp program. It will be continued for another year; it is hoped that the other agencies who are getting money for in-home health care through personal care workers or home health aides will utilize these trained AFDC mothers.

Rep. Blackwell asked for the 17 counties in the State where this Project is being implemented.

Ms. Payton enumerated Horry, Georgetown, Darlington, Jasper, Beaufort, Dorchester, mostly in the lower part of the State.*

Senator Rubin questioned whether the Federal money will terminate when the pilot project terminates.

Ms. Payton confirmed this. However, she feels that there are enough monies that have been allocated to Commission on Aging and for Long Term Care for these personal care workers and home health aides--and they can provide the homemakers already trained.

*(Additional counties are: Florence, Sumter, Richland, Fairfield, Calhoun, Orangebur, Newberry, Lexington, Berkeley, Anderson, and Laurens counties).

The Homemaker/Home Health Aide Demonstration being participated in by seven (7) states is authorized by section 966 of the Omnibus Reconciliation Act of 1980 (P.L. 96-499). The overall parameters of the demonstration, as specified by the legislation and subsequent HCFA guidelines are as follows:

1. The training and employment component is voluntary. To be eligible, trainees must have been AFDC recipients for the previous 90 days and not employed during that time. The training of 4 weeks is followed by, up to a year os subsidized full-time employment, during which medicaid coverage is continued. They receive minimum wage and fringe benefits. The training and service providers are to be public or private nonprofit agencies.

2. The service component of the demonstration consists of Hm/HHA services provided on a part-time basis (not exceeding 100 hours a month) to anyone over 18 years of age who is elderly, disabled and/or handicapped or other individuals who would be at risk of institutionalization without such services and who do not have services reasonably available to them. Clients with income above 200 percent of the state AFDC needs standard contribute to the cost of their care according to a sliding scale based on income.

The demonstration is to be evaluated by an independent evaluator to perform this role, HCFA has selected Abt. Associates, Inc.

If successful, the project could become a blueprint for wider implementation of a program that could alleviate two (2) costly social problems: 1) Welfare dependence and 2) unnecessary institutionalization.

South Carolina is presently implementing this project in 17 counties. We have trained 355 AFDC recipients at this time. 216 are presently working as aides and 55 have found employment in unsubsidized employment.

We have served a total of 660 clients. At present we are serving only 416. Services were terminated because of death, entered institutions, moved, refused services and a number of our clients felt they had gotten better and didn't need our services any longer.

This is a medicaid funded project - 90% federal and 10% state. Approximately ½ of the state match is payed from the savings from the welfare savings of the AFDC recipients going to work and being terminated from the welfare roles.

Ms. Nita Huntley
Route 5, Box 394
Darlington, SC 29532

As the daughter of an Alzheimer's victim, Ms. Huntley's testimony addressed problems caused by this degenerative brain disease.

Alzheimer's disease is the fourth leading cause of death in this country. As it is a non-allowable expense for insurance purposes, it is seldom used as an admitting diagnosis/cause of death. In South Carolina 20,000 people are diagnosed as having this disease today which generally attacks 10 percent of the population 65 and over. As the disease progresses, later survival without assistance is impossible.

Studies look at many causes, such as genetic, environmental and biological deficiencies. It is believed that the factors are not distinct and separate, but a chain of destruction. However, there is no complete data available. It is estimated that there are 1-1/2 million people afflicted by this disease and that by the year 2034 there will be 5-1/2 million victims.

Much of the research of Alzheimer's is focused on the management of the patients and the stress on the caregivers. The urgency for finding cause, prevention and cure, however, can not be ignored. In this respect, the third party payment system contaminates data collection with respect to the number of deaths resulting from Alzheimer's. Until this becomes an allowable diagnosis, health care costs cannot be accurately estimated.

Ms. Huntley said a state-wide system is needed that links research, acute and long term care facilities to a central computer storage system. This way the variety of incomplete information can be collected and stored and ultimately all facets of this data can be compared. Insurance companies should be forced to recognize Alzheimer's and cover charges associated with this disease.

Senator Rubin said that a lot of research is being done in this field. The disease has just been recognized in recent times. "We try to figure out how we can help."

Ladies and Gentlemen, the fourth leading cause of death in this country is non-allowable expense for insurance purposes. Therefore, it is rarely used as an admitting diagnosis/cause of death. The disease is Alzheimer's. It generally attacks that 10 percent of our population 65 and up.

Today in South Carolina 20,000 people who use to antisipate the prestige of retirement are diagnosed as having a type of degenerative brain disease known as Alzheimer's. This diagnosis is one of exclusion and here in lies the delima. To come to the diagnosis we must first rule out medical, neurological and psychiatric etiologies for cognitive decline. We use to think memory loss was a normal part of aging but today we know that just is not true. For 20 percent of the population over 65 its the first of symptoms of an insideous Alzheimer's disease.

The symptoms at first are misplacing objects, forgetting a procedure/name, the inability to retain written material,

getting seriously lost when traveling, anxiety over employment/ social demands, and work performance may suffer.

As the disease progresses they display decreased knowledge in recent events, and personal history. Withdrawl from previously challanging situations is observed.

Later survival is impossible without assistance. The patient may forget his home address, phone number, and family names. There's disorientation to time, place and proper clothing needed. Loss of continence and day vs night (diurnal) rhythm, is likely--personality and emotional changes can devastate a family---loss of speech--loss of ability to walk---death. Thought only listed as cause of death 35 times last year.

Studies look at genetic causes, environmental deficiencies, biological deficiencies, molecular pathology, slow virus, and trace metals. Most believe when the answers come they'll reveal these factors are not distinct and seperate, but more likely a chain of destruction. This explains upsetting the body's ability to sustain,

repair, and defend itself.

We know that Alzheimer's kills the cells in the part of the brain known as the Cerebral Cortex. We do not know why it selectively kills only those cells.

The volumes of incomplete data are frustrating and frightening. How can we get a handle on an epidemic whose very existence cannot be confirmed without tissue examination? How do we research an illusion? It is no illusion that one and one-half million people are in the clutches of an insidious thief who robs them of the rewards of a lifetime of work and savings. It is no illusion that by the year 2034 AD that number will be five and one-half million victims. It is no illusion that state institutions and nursing home beds are being unindated with globally impaired, confused and disoriented, sixty-five, seventy-five and eighty-five year old people who should be enjoying the bounty of a long productive life.

What cost for health care? The present system of "non-allowable" charges for diagnostic exclusions does not void the

financial responsibility of a senior adult to pay for the medical work-up. The already confused patient is bombarded with forms to be filed, bills to be paid, covered and non-covered charges, reason codes, special deductibles, and the imfamous "02" (charge in process). God willing, there is a caring person around to be legal secretary, financial advisor, nurse, and friend when the pox erupts.

And if the victim finds himself alone, what then? Third party payments can be a nightmare. Is it not more economically sound to rule out other pathologies, than to spend needless dollars treating the symptoms of depression/anxiety to the detriment of an Alzheimer's victim? Would that money not be more wisely spent to support programs of respite day care to relieve patient and family stress, reduce accidents, or infection? If so, then insurance companies may need legislative encouragement to amend their priorities.

The one thing that the present system of third party payment seems to do is contaminate data collection with respect to

number of deaths as a result of Alzheimer's. Until this becomes an allowable diagnosis, the health care cost will remain a frightening estimate while the emotional cost grips more and more families.

As the number of Alzheimer's patients increase, so do the research projects, and the families who are gripped by its insidious presence. Much of the current research is focusing on the management of the patient and, or stress management for care givers. This avenue obviously has immediacy. However, with the projected population of those 65 years and older reaching the 5.5 million mark in the next 50 years, causality, prevention, arrest, and cure take on an urgency which can not be ignored. Many researchers are engaged and actively pursuing answers.

The data collection and storage system in this state is not as organized as one would expect, considering the magnitude of the problem. To capture, compare and utilize the variety of incomplete information, a state-wide system linking research,

acute and long term care facilities to a central computer storage system is needed. Force insurance companies to recognize and cover the charge associated with this nightmare.

Only by comparing all facets of the data as they related to and impact on each other can we hope to find the answers that can relieve the fear that chokes us when we hear the diagnosis Alzheimer's.

Ms. Yvonne S. Simpson, Director of
Aging Unit
Area Agency on Aging
S. C. Appalachian Council of Governments
Greenville, SC

The Council serves as the Area Aency on Aging for Anderson, Cherokee, Greenville, Oconee, Pickens and Spartanburg counties. Ms. Simpson briefly updated the Committee on some of the activities in Appalachia: (1) newly renovated senior citizens centers in Anderson, Gaffney and Clemson have either opened or will open by the end of October (2) a Homemaker/Home Health Aide Program funded by DSS has been implemented in Anderson County and hopefully will expand into other areas of this region; (3) Appalachia continues to lead the State in providing adult day care services to the elderly.

The following issues of concern were addressed:

1. Support the Commission on Aging's Community Services Program.

2. Review of current formula funding under the Older Americans Act. Asked that review will be equitable to all parts of the State.

3. Support of Adult Day Care Services in the communities.

4. Support of "lifeline" telephone rates for the elderly.

Representative Blackwell asked what percentage of the total population falls into Appalachia.

Ms. Simpson replied that as of the 1980 census, Appalachia has 114,351 older people--about 27.5 percent of the total aging population in the State. In addition to that, 27 percent of the people below the poverty level in this State also reside in the six counties served by the Appalachian Council of Governments. A Task Force is looking at some options with regard to the formula, and there will be a public hearing to discuss this further.

Representative Blackwell instructed her to "do all you can to hold the line for Greenville County..."

PRESENTATION OF YVONNE S. SIMPSON
Director of Aging Unit - Area Agency on Aging
S. C. Appalachian Council of Governments

BEFORE THE LEGISLATIVE STUDY COMMITTEE ON AGING
SEPTEMBER 20, 1984

SENATOR RUBIN, MEMBERS OF THE COMMITTEE

I AM YVONNE SIMPSON. I SERVE AS THE DIRECTOR OF THE AGING PROGRAM FOR THE SOUTH CAROLINA APPALACHIAN COUNCIL OF GOVERNMENTS. THE COUNCIL SERVES AS THE AREA AGENCY ON AGING FOR THE COUNTIES OF ANDERSON, CHEROKEE, GREENVILLE, OCONEE, PICKENS, AND SPARTANBURG. I AM HERE THIS AFTERNOON FOR TWO MAIN PURPOSES. FIRSTLY, AS A LEGISLATIVE STUDY COMMITTEE SPECIFICALLY CONCERNED WITH THE NEEDS OF OLDER SOUTH CAROLINIANS, I WANT TO GIVE YOU A BRIEF UPDATE ON ACTIVITIES IN APPALACHIA. SECONDLY, I WOULD LIKE TO SHARE WITH YOU OUR PERSPECTIVE AND RECOMMENDATIONS FOR SOME OF THE MANY ISSUES OF CONCERN TO OLDER SOUTH CAROLINIANS.

SINCE I SPOKE BEFORE YOU LAST YEAR, SEVERAL ACTIVITES HAVE OCCURRED. NEWLY RENOVATED SENIOR CITIZENS CENTERS IN ANDERSON, GAFFNEY, AND CLEMSON EITHER HAVE OPEN ED OR WILL OPEN BY THE END OF OCTOBER. A HOMEMAKER/HOME HEALTH AID PROGRAM FUNDED BY THE DEPARTMENT OF SOCIAL SERVICES HAS BEEN IMPLEMENTED IN ANDERSON COUNTY AND WE REMAIN HOPEFUL THAT THIS PROJECT WILL EXPAND INTO OTHER AREAS OF OUR REGION. FURTHERMORE, IN SPITE OF FUNDING CUTS, WE CONTINUE TO LEAD THE STATE IN ADVOCATING FOR AND PROVIDING ADULT DAY CARE SERVICES TO THE ELDERLY. SHARED HOUSING PROGRAMS HAVE ALSO BEEN IMPLEMENTED IN ANDERSON, GREENVILLE, AND SPARTANBURG COUNTIES. AND, WITH INCREASED POSITIVE EXPOSURE FROM THE NEWS MEDIA IN OUR AREA, MORE OLDER PEOPLE ARE BECOMING AWARE OF SERVICES AVAILABLE AND NOT AVAILABLE TO THEM.

I WOULD ALSO LIKE TO INFORM YOU OF THE FOLLOWING ISSUES OF CONCERN TO APPALACHIA'S ADVOCATES AND OLDER PEOPLE AND TO ASK THAT YOUR CONSIDER THESE AS YOU DEVELOP YOUR LEGISLATIVE PRIORITIES.

1. WE CONTINUE TO BE SUPPORTIVE OF THE REQUEST OF THE STATE COMMISSION ON AGING FOR A COMMUNITY SERVICES PROGRAM. THIS PIECE OF LEGISLATION WAS INDICATED AS H2364 DURING THE PREVIOUS LEGISLATIVE SESSION. IT IS NO NEWS TO ANY OF US THAT ALL INDICATIONS ARE THAT PEOPLE ARE LIVING LONGER AND THAT HEALTH CARE AND NURSING HOME COSTS CANNOT CONTINUE TO ESCALATE AT THE CURRENT RATE. WE THEREFORE <u>NOW</u> NEED TO EMPHASIZE PREVENTATIVE PROGRAMS

THAT WOULD GIVE OTHER, LESS COSTLY CARE IN THE OLDER PERSON'S OWN COMMUNITY. IT IS BOTH IMMORAL AND UNREASONABLE FOR A 100 YEAR OLD SOUTH CAROLINIAN TO HAVE LIVED ALL OF HER LIFE IN ANDERSON COUNTY AND TO HAVE HER SENT TO A NURSING HOME AT THE OTHER END OF THE STATE SIMPLY BECAUSE THERE ARE NO NURSING HOME BEDS FOR HER IN HER AREA, NOR ARE THERE ENOUGH COMMUNITY SERVICES TO KEEP HER IN HER OWN HOME. YET THIS HAS HAPPENED AND CONTINUES TO HAPPEN FAR TO OFTEN IN SOUTH CAROLINA.

2. WE UNDERSTAND THAT EFFORTS ARE UNDERWAY IN THE STATE TO REVIEW THE CURRENT FORMULA USED FOR FUNDING VARIOUS SERVICES UNDER THE OLDER AMERICANS ACT. WE TRUST THAT THIS REVIEW AND THE DECISIONS MADE WILL BE EQUITABLE TO ALL PARTS OF THE STATE, INCLUDING APPALACHIA'S 114,365 OLDER PEOPLE, MANY OF WHOM LIVE BELOW THE POVERTY LEVEL.

3. APPALACHIA CONTINUES TO BE A LEADER IN ADVOCATING FOR ADULT DAY CARE SERVICES. IF FAMILIES ARE TO CONTINUE TO PROVIDE SUPPORT AND SERVE AS CAREGIVERS FOR OLDER PEOPLE, WE AS PUBLIC SERVANTS AND SERVICE PROVIDERS ARE CALLED UPON TO PROVIDE THE KINDS OF SERVICES IN THE COMMUNITIES THAT WILL HELP THESE FAMILIES. ADULT DAY CARE IS THIS KIND OF SERVICE. I WOULD INVITE EACH OF YOU, IF YOU HAVE NOT ALREADY DONE SO, TO VISIT AN ADULT DAY CARE CENTER AND TO HEAR THE COMMENTS OF THOSE FAMILIES AND ELDERLY PEOPLE WHO BENEFIT FROM THIS PROGRAM.

4. FINALLY, LAST YEAR, I MENTIONED THAT A CONCERN OF MANY OLDER CITIZENS WAS HOW LONG COULD THEY AFFORD A TELEPHONE. SINCE THAT TIME, BASIC PHONE COSTS HAVE INCREASED AND MANY OLDER PEOPLE ARE IN RISK OF LOSING WHAT IN MANY CASES IS THE ONLY MAJOR LINK WITH THE COMMUNITY. WE THEREFORE SUPPORT "LIFELINE" RATES FOR THE ELDERLY.

I THANK YOU FOR THE OPPORTUNITY TO SPEAK BEFORE YOU AND WOULD BE HAPPY TO ANSWER ANY QUESTIONS YOU MAY HAVE.

Ms. Susan Carlton, RSVP/Foster Grandparent
Program Director
S. C. Older Americans Volunteer Program Directors
Association
Suite 3-C, 1800 Main Street
Columbia, SC 292021

There are 11 Older American Volunteer Programs in South Carolina.

Eight Retired Senior Volunteer Programs serve 12 counties. They recruit people over 60 for volunteer work in a number of nonprofit organizations and projects and assist some volunteers with travel and meal expenses, transport those who do not drive and provide insurance for all. There are 4,156 RSVP'ers statewide who serve 673,800 hours per year.

There are two Foster Grandparent Programs that serve the Midlands and the Low Country. Volunteers must also be 60, but unlike RSVP'ers, they must meet income guidelines to qualify and work 20 hours a week with special need children. In addition to a stipend of $2/hour, they receive other fringe benefits. Statewide there are 114 Foster Grandparents providing 119,000 hours of care for about 285 children each year.

The Senior Companion Program in Orangeburg and Calhoun Counties is composed of 60 volunteers who serve 125 frail elderly people. Two companions serve in adult day care centers; the other 58 care for two people daily in their own homes and thus are keeping them out of institutions for as long as possible. These volunteers also receive a stipend.

She asked for $85,000 to be earmarked for the Older American Volunteer Programs in South Carolina. This is $85,000 in addition to the money presently allocated for aging programs. Some of their programs do not get enough local funds to match their Federal grants. All but two of them are sponsored by Councils on Aging whose State dollars are set aside for other aging programs. Only one Older American Volunteer Program receives State money through the aging network.

The last time their programs received an increase in Federal funding was in 1980. They may receive an increase in the next year or two, but this might not be made at all if the Federal budget is cut. Georgia, for example, is one of several Southern States that has State funds earmarked for OAVP.

Ms. Carlton believes that their programs are cost effective. For example, the volunteers live healthier fuller lives because of the work they do. You might go so far as saying that "we keep them out of nursing homes." By keeping just one percent of them out of nursing homes, we are saving the State and Federal governments at least $619,200 a year (based on the rate of $1,200 per month per nursing home patient). If we consider the number of other elderly who can stay at home because of these services, the figure of cost savings grows.

With $40,000 the RSVP's could add 300 more volunteers; with $30,000 more the Foster Grandparents Programs could add at least 10 new grandparents; with $15,000 the Senior Companion Program could add 5 new companions. Considering all this, "$85,000 does not seem like much money."

Senator Rubin asked if a request has been made to the State in the past for this funding or is this a new type of program.

Ms. Carlton explained that it is a new program and no request has been made to the State. They have talked to a legislator about the possibility of introducing legislation, but that was as far as they got.

Representative Waldrop wanted to know if the $85,000 would be divided among the chapters in the State.

Ms. Carlton thought that this is something they will need to decide. After discussing the needs of each RSVP program they decided $5,000 per project would be a small amount. Some projects are already lacking as much as $5,000 to match the grant they got. Roughly that is $5,000 per RSVP and $15,000 per Foster Grandparent Program and Senior Companion Program. It costs much more money to keep a Foster Grandparent at work than it does a RSVP because of the stipend involved.

Dr. Parrish wanted to know from where their basic money comes from--do they work from the same formula as the Appalachian people, 90:10.

Ms. Carlton explained that ACTION, the Federal umbrella agency for volunteerism which has the State office here in Columbia, gives seed grants to sponsors. In South Carolina they are all councils of aging except for a CAP agency in Orangeburg and the Lowcountry Red Cross. Her association is considered part of the aging network although they are not really funded nor considered in the aging network,except

by their own sponsors. The RSVP's have to match at least 30 percent over and above their grant. Their grant in Richland County, for example, on which they support 650 volunteers has a total Federal grant of $39,000, and until 1980 the grant was in the amount of $18,000 and she had 300 volunteers with that.

TESTIMONY
To S. C. Legislative Study Committee on Aging
September 20, 1984
by
Susan Carlton, representing S.C. Older American Volunteer Program
Directors Association

Senator Rubin, ladies and gentlemen:

The South Carolina Older American Volunteer Program Directors Association is an organization of program directors and our associates who meet together to exchange ideas on our work with senior volunteers in South Carolina. There are, as you may know, eleven older American Volunteer Programs in the State.

The 8 Retired Senior Volunteer Programs serve 12 counties: York, Spartanburg, Charleston, Dorchester, Berkeley, Colleton, Florence, McCormick, Newberry, Greenville, Richland and Lexington. They recruit people over 60 for volunteer work in all kinds of non-profit organizations and projects. The programs help some volunteers with travel and meal expenses, actually transport others who do not drive, and provide insurance for all. The volunteers serve 673,800 hours a year in an enormous variety of assignments that help people of all ages. We have 4,156 RSVP'ers statewide.

The two Foster Grandparent Programs serve the Midlands and the Low Country. Like RSVP's, Grandparents must be 60, but, unlike RSVP's, they must meet income guidelines to qualify and are expected to work 20 hours a week with children who have special needs. The Grandparents receive a free annual physical, transportation or reimbursement for travel, free meals, insurance, and a stipend of $2.00 an hour. In South Carolina our Grandparents are known for their work with retarded children but are now branching out into headstart, work with special children in the public schools, and with teenagers in trouble. You will be interested to know that, at present, 77 Foster Grandparents work through the S.C. Department of Retardation and three are being placed at S.C. Department of Youth Services. Although these state agencies contribute support to the Grandparents in the form of meals, physicals and some transportation, there is no doubt that the state receives far more than it gives. If the state had to pay minimum wage for the 83,520 hours they give each year, it would amount to $279,790. Statewide there are 114 Foster Grandparents providing 119,000 hours of tender care to at least 285 children each year.

The Senior Companion Program in Orangeburg and Calhoun Counties operates similarly to the Foster Grandparent Programs in that volunteers receive a stipend. Instead of children, however, the Companions serve frail elderly people. I would note that the Companions have been working in long term care since 1976. Two Companions serve in adult day care centers; the other fifty-eight care for 2 people daily in their own homes, effectively keeping them out of institutions for as long as possible. There are 60 Companions providing care for 125 older people five days a week. They serve 62,640 hours annually.

I am here today to ask you for $85,000 to be earmarked for the Older American Volunteer Programs in South Carolina. Some of our programs are stifling for lack of local funds with which to match their federal grants; others have waiting lists of volunteers who need travel reimbursement in order to serve; still others experience high staff turnover, partly due to inadequate salaries and support staff. All but two of us are sponsored by Councils on Aging, whose state dollars are mostly earmarked at the state or area agency level for other aging programs. Only one OAVP receives state money through the aging network. The irony is that although our programs preceded most of the present aging services, we have been inadvertently left out of the mainstream of state funding for Older Americans Act Programs throughout our history. Our sponsors' county, United Way and other local dollars are being stretched for the needs of all the programs they operate. Though they might want it otherwise, there is only so much left for us. Consequently, some directors are spending their time and energies on fundraising, too often to the detriment of our purpose, which is the recruitment and placement of older volunteers in community service.

The last time our programs enjoyed an increase in federal funding was in 1980. We may receive an increase in the next year or two, though the appropriations are not final and might not be made at all if the federal budget is cut. In any event, we are informed by ACTION that existing projects will receive only part of the money that Congress is considering; that emphasis will be on establishing new OAVP's nationwide. Possibly South Carolina will be considered for a new project somewhere and our Association is concerned about that, too. In 1980, part of ACTION's increase in OAVP funding helped to start a new RSVP in the State. To our dismay, it failed within the first year and when no other sponsor could be found that could undertake the matching of the grant, it was lost to Georgia. Incidentally, Georgia is one of several Southern states that has state funds earmarked for its Older American Volunteer Programs.

We want to be clear that we are not asking for part of the money presently allocated for Aging Programs. We are asking for $85,000 more to be allocated for the unique services provided by the OAVP's. These are not merely aging services because the work of our volunteers affects many people's lives while, at the same time, enriching their own. So in funding the senior volunteers, you will, in fact, have impact on a myriad of other social issues ranging from public education to longterm care for the elderly, from child abuse to health education, from retardation to juvenile justice and many more. What distinguishes our programs from all the rest, is that we view the older person as the service provider and, in turn, our communities benefit from the experience and time they give.

We believe that our programs are effective in human terms,as well as cost effective.. The volunteers themselves live longer, healthier, fuller lives because of the work they do. Indeed, we would go so far as to say that we keep some out of nursing homes. And if we are keeping even 1% of them out of nursing homes, we are saving them, their families and the state and federal governments at least $619,200 a year.* If we consider the number of other elderly people that can stay at home because of their services, that figure grows. Let's say that as few as one-fifth of the older people served by the Senior Companions are kept out of nursing homes and that 5 more are kept home because of RSVP's, that's a total of $432,000 we all have saved. And what about the value of all the tutoring they do in our public schools or of the health education they provide that enables all of us to prevent illness and, in turn, keeps down hospital costs? I already noted the worth of Foster Grandparents to state agencies. That did not include the hundreds of hours served by RSVP's in state offices here in the capital city or in branch offices statewide.

Think about the social services the volunteers offer through local agencies that otherwise would have to turn away citizens in need. Consider how much richer we all are because of the interaction of old and young in some of our placements. What if a Foster Grandparent or an RSVP volunteer keeps just one juvenile offender from a lifetime of crime. In pure monetary terms it saves thousands of tax dollars in law enforcement and prison costs. More importantly, it results in a good citizen for the community.

*Based on the modest rate of $1,200 a month per nursing home patient.

In the face of this, $85,000 does not seem like much money. With $40,000, the RSVP's could add on 300 volunteers to serve 46,800 additional hours each year. With $30,000 more, the Foster Grandparents' Programs would add on at least 10 new grandparents to provide 10,440 hours of love and attention to children with special needs. With $15,000, the Senior Companion Program could add 5 new companions to give 5,220 hours of attention and care to the frail elderly, perhaps expanding its services into Bamberg County. You might even consider in your longterm care planning the possibility of funding some entirely new Senior Companion Programs. The model is well worth looking at for its cost effectiveness, if nothing else.

In conclusion, I reiterate that through the years we have all done a lot with very little money, but there is so much more we could do with just a little more!

Thank you.

William K. James, Commissioner
S. C. Commission for the Blind
1430 Confederate Avenue
Columbia, SC 29201

Commissioner James spoke to the needs of one particular group of the aging population--those of the blind in South Carolina, 65 and over.

Half of the people over 65 have a serious visual impairment and in this State approximately half of the blind people are 65 or older. Statistics show that the incidence of blindness affects the elderly population. The basic concern is to ask ourselves how much we can do to meet the needs of this very deserving segment of our population. "Many of these individuals could look toward their abilities rather than disabilities if they could cope with aging and blindness."

Unfortunately, most of these people are not eligible for services under the Commission for the Blind or other agencies, because of their age and other multiple disabling conditions. For example, to be eligible as a vocational rehabilitation client you have to be a homemaker raising children or be able to release somebody else in the home for employment. Without immediate attention to this problem, these people are forced to rely on their families or are placed in institutions or nursing homes. However, with proper training they could lead productive and satisfying lives.

To cope with blindness you have to rely on your other senses; however, due to the aging process the other senses are also impaired, such as hearing. This complicates the process of making an adjustment to blindness and often these people resign themselves to a life of hopelessness and helplessness.

To begin to address the needs of the elderly blind, the S. C. Commission for the Blind is proposing a multi-faceted statewide program to serve the needs of this targeted population. There are three basic needs: (1)independent living skills (eating, dressing, bathing); (2) orientation and mobility (learning the techniques to walk around in a room, go to the mailbox); and (3) social support services (information and recreation services).

The Commission intends to acquire a van which will be equipped with necessary teaching and training equipment to support an outreach program in a client's home or community center.

Further, the Commission will work in close cooperation with the S. C. Commission on Aging to utilize their transportation system and community resources and also to learn where these people are who are in need of these services.

They propose to employ two independent living instructors to staff the van, and a part-time secretary to provide clerical support for this service. The two instructors will also provide professional training to local COA staff to assist them to work with the blind as well as provide training to nursing home staff.

In addition, they will work with those blind individuals who have made a satisfactory adjustment, helping them to work with other blind people either in group situations or individual counseling.

The Commission for the Blind Education Radio Program will furnish radio receivers to elderly blind and will provide programming directed at their specific needs; such as, wellness, nutrition, available benefits, etc.

The Commission proposes to request State funding in the amount of $75,000. If you consider that it costs about $10,000 to maintain a handicapped person in the home--compared to $30,000 in an institution--you can readily see that if only 4 people could continue to live in their own homes instead of being institutionalized, it would save the State money. Thus you can readily see that the Program would be cost effective.

At the present time there are no services available for the elderly blind in the State--there are no resources to even supply them with a cane. As the new Director of the Commission, Mr. James is proud of the services being provided; however, he does not believe that "we can allow this kind of need to continue and not be addressed."

He expressed his hope that the Committee will support the Commission in its efforts to establish this new Program to meet the needs of this small but very deserving group of individuals.

Senator Rubin welcomed the new Commissioner who came from Pennsylvania on July 1 to take over the Commission for the Blind. He told him that he has done a lot of work with the blind and is on the Board of the Federation for the Blind. "This State has been very reasonable and understanding in its attitudes, and I would anticipate a lot of support for the projects that you feel we should help you with."

Representative Waldrop mentioned that Mr. Bryan endorsed this Program earlier in the Hearing. He expressed his admiration for the blind and would like to see this money appropriated to the Commission.

Mr. James thanked him for his words and support.

Senator Rubin added that we admire their self-reliance which is very inspiring. "We are with you to the full extent we can be."

south carolina
commission for the blind

1430 CONFEDERATE AVENUE • COLUMBIA, SOUTH CAROLINA 29201
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William K. James, Commissioner

September 20, 1984

STATEMENT TO S. C. STUDY COMMITTEE ON AGING

South Carolina has shown a marked increase in its elderly population from 1960 to 1979. During this twenty-year period, the South Carolina Abstract of 1980 states there has been a 78.6% increase in the elderly population. With these increasing numbers in the population of the elderly also becomes a greater awareness of the many physical disabilities associated with growing older.

Half of the people over age 65 have a serious visual impairment. Approximately half of the blind people in South Carolina are 65 years of age or older. Statistics from surveys conducted locally and nationally indicate that the incidence rate of blindness is highest among the elderly population. The numbers can go on and on to indicate that the elderly blind in South Carolina do exist; however, knowing how many is not enough.

The South Carolina Commission for the Blind is concerned with dealing with how much; how much we can do to provide services to this very needy segment of our population - a population comprised of individuals who have rendered countless contributions to society, thus improving the quality of life for all of us. Many of these individuals could continue to look towards to their ability rather than disabilities if they could successfully cope with aging and blindness.

The elderly blind in most instances is ineligible for vocational rehabilitation services provided by agencies such as the S. C. Commission for the Blind. Age and multiple handicaps very often are the primary reasons they are ineligible. Without immediate attention to the needs of the elderly blind, we will continue to have these individuals dependent upon their families and placed in institutions and nursing homes when they could continue with proper training and assistance to lead productive and satisfying lives.

In order to adequately cope with blindness, it is necessary to learn to depend upon your other senses. At the time they are most needed, many elderly persons find that these other senses, such as hearing, are also greatly impaired. Other disabling conditions greatly complicate the ability to adjust to blindness and result in lives of helplessness and futility.

Statement to S.C. Study Committee
on Aging—contd. September 20, 1984

In order to begin addressing the needs of the elderly blind, the S. C. Commission for the Blind proposes to offer a multi-faceted statewide program of services targeted at their priority needs. These needs are independent living skills, basic mobility skills, and social support services including informational and recreational programs.

The S. C. Commission for the Blind intends to acquire a van that can be equipped with the necessary independent living evaluation and training equipment to support an outreach program conducted in the client's home or a community center. The Commission will employ two independent living instructors to staff the van. They will have the expertise required to evaluate client needs, develop a plan for service, provide and coordinate the services, and evaluate client outcomes. Instructors must be knowledgeable in the area of blindness and geriatrics. A part-time secretary will be employed to provide clerical support.

The Commission proposes to work in close cooperation with the S. C. Commission on Aging. The Commission on Aging through its existing programs and contacts can assist the Commission in locating eligible clients. The local facilities and the transportation network of the Commission on Aging will be utilized to provide services for clients. In addition to direct client services, the independent living instructors will also provide professional training to local COA staff to assist them to work with the blind, provide training to nursing home staff to assist them to better serve their clients, and provide training for elderly blind persons who are able to act as peer counselors to conduct group sessions and counsel with clients on an individual basis.

The Commission's Educational Radio Program will provide radio receivers to the elderly blind and develop informational radio programs on topics of interest to this group, including wellness, nutrition, client rights, and available benefits and services.

The Commission proposes to request $75,000 in state funds to conduct this program. It costs approximately $10,000 to maintain a handicapped person in their home. The cost for maintaining this individual at an institution is approximately $30,000. Thus, it can be readily seen that if only four persons can be prevented from having to live in an institution, this program would be cost effective. There is no way to put a price tag on human dignity or having the ability to live independently in your own home.

At the present time, the S. C. Commission for the Blind has no resources to meet the needs of these forgotten citizens. As the new Commissioner of the Agency, I am very proud of the services being provided by our Agency; however, I do not believe that we can allow the needs of these people to be neglected. In my opinion, these people are being denied their basic right, as they do not have the opportunity to acquire the basic skills of activities of daily living that you and I take for granted.

"Show the people the light and they will find their own way." Now that you are aware of the plight of these elderly blind and visually impaired persons, I am hopeful that you will support the Commission for the Blind in our efforts to bring hope back into the lives of these deserving people.

Ms. Dorothy Maysey, Consultant
Health Education
SC Dept. of Health and Environmental Control
2600 Bull Street
Columbia, SC 29201

The presentation addressed the matter of Health Promotion Programs for the Elderly.

As stated numerous times by different people at this hearing, the elderly utilize the health care system more than any other group. Absorbing this cost will fall primarily on government payers; however, government has come to realize that they are no longer financially capable of absorbing this ever increasing cost. Alternatives to expensive institutional care are being explored and preventive health programs for the elderly are being implemented.

In September of 1983 a joint national initiative started to develop and expand health promotion programs for the elderly in the areas of injury control, appropriate drug use, nutrition and physical fitness. Governor Riley named the Commission on Aging and DHEC as joint lead agencies in health promotion activities for the aging.

Health promotion focuses on behaviors that would increase the number of years of active and independent life. One example of health promotion is the national campaign to stop smoking. Other areas of concern are proper eating habits, regular exercise, and correct usage of medications.At this time a statewide network of groups with expertise in drug use, exercise, nutrition, accident prevention and mental health is being organized jointly by the Commission on Aging and DHEC. Local councils on aging have received materials encouraging the implementation of health promotion initiatives using local resources. The Office of Health Education, DHEC, is funding pilot health promotion programs--conducted by a graduate student in health education from USC--to be tested with different groups of the elderly. However, future programs and statewide expansion will depend on additional funds and support of these health promotion programs is needed. Also, with the projected increase in the elderly population over the next five years, there will be a growing need for health educators with training in gerontology.

Ms. Maysey has been with the Department for the past four years and has been involved with health promotion with other groups, but this initiative is new with respect to the elderly.

This concluded the Hearing.

I am Dorothy Maysey, representing the Office of Health Education, South Carolina Department of Health and Environmental Control. Today I want to bring to your attention the need for health promotion programs for the elderly.

In the past decade, the proportion of individuals over the age of 65 residing in South Carolina has increased 50% (from 190,960 in 1970 to 287,287 in 1980). The aged population in the State has realized a growth from only 3% of the total population in 1900 to over 9% in 1980. And it is estimated that this group will continue to increase in the next five years to make up more than 10% of the State's population.

One of the systems directly impacted upon by the increasing older population will be the health care system. The elderly experience more physical limitations and disabilities due to their increased age and infirmity and as a result utilize the health care system more than any other subgroup.

Absorbing the cost of providing health care to the elderly will fall primarily to government payors (three-fifths of all health care costs for the aged are covered by federal, state and local government). Yet the rapid increase in health care costs has caused government to recognize that they are no longer financially capable of continuing to absorb large uncontrollable costs without injury to other needed services for the population in general. Consequently, alternatives to expensive institutional care are being explored

and preventive health for the elderly is being fostered by all levels of the health care system. (Special Study Supplement ot the 1982 State Health Plan)

The final report of the White House Conference on Aging, issued in 1982, gave high priority to health promotion. Specifically it said the health policy of the nation should be to (a) improve the health of Americans, especially the elderly; (b) curtail health care costs; and (c) focus attention on health promotion and disease prevention.

In September, 1983 a memorandum of understanding between the Public Health Service and the Administration of Aging was drawn up to launch a joint national initiative to develop and expand health promotion programs for the elderly. Health promotion activities targeted for the elderly were in the areas of injury control, appropriate drug use, nutrition and physical fitness. As part of this effort, Governor Riley named the Commission on Aging and the Department of Health and Environmental Control as joint lead agencies in health promotion activities for the elderly in South Carolina.

What does health promotion mean for the elderly? In general, health promotion could be described as the encouragement of individuals to make voluntary behavior changes which would reduce their risk of dying prematurely of causes over which they have some control. An example of health promotion is the national campaign to reduce the number of people who smoke cigarettes. Cigarette smoking puts individuals at much greater risk of

developing lung cancer, dying of heart disease, or having a low weight baby. For the elderly, those 65 and older, health promotion focuses on those behaviors which would tend to increase the number of years of active and independent life. As the Surgeon General suggested in Healthy People, we have succeeded as a society in helping more people to live longer. We should now look at another goal: "a better, healthier life for older people." Often, the limitations placed upon the individual by chronic and acute conditions inhibits the older person's ability to create an old age lifestyle of their choosing. The long term goal of health promotion and disease prevention programs for the elderly must be to allow each individual to seek an independent and rewarding life in old age, unlimited by many of the health problems that are within his or her capacity to control. In a recent article in the New England Journal of Medicine Sidney Katz and others discussed a study to demonstrate the feasibility of forecasting functional health for the elderly. The group analyzed the expected remaining years of functional well-being in terms of activities of daily living for noninstitutionalized elderly people who were living in Massachusetts in 1974. The study found active life expectancy was 10 years for those aged 65 to 70 years but decreased to 2.0 for those 85 years and older. Active life expectancy was longer for the nonpoor than for the poor. Associated with the shorter life expectancy of men, the percentage of remaining independent years of life for men was larger than for women. The percentage of remaining dependent years

was larger for women. The study concluded that projections of active life expectancy could be useful in identifying high risk populations for preventive health care and health promotion activities. The objectives of these activities would be to increase the number of elderly living independently for a longer period of time before death.

That seems to be what individuals, families and society would want -- to maximize the number of years of active and independent life for older South Carolinians.

Health promotion activities are certainly no panacea, but research has demonstrated that behavior changes do make a difference in risks associated with many illnesses and causes of death. In the most recent National Health and Nutrition Examination Survey over eighty percent of the elderly have a daily caloric intake below the recommended level. In addition to calories, many elderly fail to eat the recommended levels of protein, vitamins and minerals for optimal well-being. Because diet has been directly linked to disability, it is important for the elderly to maintain a balanced diet (State Health Plan). Eating a healthy diet provides the body with energy, strength and an increased ability to resist infection and disease. Inactivity is accompanied by a cycle of poor circulation, muscle atrophy, reduced strength and endurance, reduction in density of bones, and fatigue. Regular exercise interrupts this cycle, affording a person greater strength, more agility, and improved balance which can be used to stop falls or to mitigate injuries.

Through physical activity, a person increases the likelihood of remaining mobile and of remaining independent in old age.

. Osteoporosis, or fragile bones, is related to diet and exercise. This is particularly a problem for older white women. Bones break, causing hospitalization, followed frequently by nursing home care and dependency. This could be avoided through increased calcium consumption in the diet and appropriate exercise, both health promotion activities. Prevention of accidents, especially in the home, is another area where attention to the environment and small changes in habits can decrease the probability of injury and possible death. The highest rate of accidental death and injury occurs among the elderly. Their risk of fatal injury is almost twice that of adolescents and young adults. Relatively simple and inexpensive accident prevention measures such as illumination of walking surfaces, handrails, smoke detection systems, elimination of smoking in bed, use of seat belts and optimum vision and hearing care, can significantly reduce the risk of accidental injury and death for older persons (Health People). Misunderstood and incorrectly used medications are frequently linked with physical and mental health problems of the elderly. Recently, Shawn Chillis, MD and faculty member in the School of Medicine at the University of South Carolina, stated that 75 percent of over-the-counter drugs were bought by 25 percent of the population, the elderly. Encouraging the elderly to be careful medication consumers by asking questions about drug interactions and by

keeping careful records of all medications taken, discussing all drugs used with their physician or pharmacist are examples of health promotion activities addressing this risk behavior. Mental health and social support from friends and family members are crucial to the promotion of self care, independence and self responsibility and should be an underlying part of all health promotion activities. In May 1984 a survey was given to participants in a Commission on Aging state conference. Most of the participants were staff of local councils on aging, health departments or nutrition sites. Developing social support systems (82%) was the most frequently indicated activity that the respondents felt needed more attention, followed closely by physical exercise (80%). The next three areas where increased attention was needed were accident prevention (65%), proper drug use (62%) and nutrition education (58%).

At this time a statewide network of groups with expertise in drug use, exercise, nutrition, accident prevention, and mental health is being organized, jointly by the Commission on Aging and the Department of Health and Environmental Control. Local councils on aging and health departments have received materials encouraging the development of local health promotion initiatives utilizing local resources. The Office of Health Education, DHEC, is developing pilot health promotion programs to be tested with different groups of the elderly. These pilots will have an evaluation component assessing behavior change and change of health status. The pilots will be conducted by

a graduate student in health education from the University of South Carolina. Funds to initiate these pilot efforts were provided by the Office of Health Education. However, future programming and statewide expansion will bedependent upon the identification of additional funds. With the number of elderly in the state projected to increase to 10% of the population over the next five years, there will be a growing need for health educators with training in gerontology to provide these services.

The committee's support of health promotion initiatives for the elderly is needed. Any suggestions you could give in how best to engage the elderly in health promotion activities is greatly appreciated.

Charleston-Trident Dietetic Association

153 Ponderosa Drive, Ladson, S. C. 29456

September 11, 1984

Ms. Keller H. Bumgardner
P.O. Box 142
305 Gressette Building
Columbia, S. C. 29202

Dear Ms. Bumgardner:

The members of our organization would like to present a brief written statement to the Joint Legislative Study Committee on Aging in lieu of appearing to present oral testimony at the public hearing on September 20, 1984.

The attached statement was prepared by Ms. Eileen Schleelein, M.S., R.D.. Ms. Schleelein performed a "community assessment" of the Charleston County area one year ago and presented her findings to the Charleston County Nutrition Council in the form of an educational program for members. She and other council members were shocked at the very low percentage of elderly citizens who were able to receive the services of home-delivered meals, congregate meals, homemaker services, public transportation and subsidized housing. The council has since held several public meetings to enlist community support to develop a home-delivered meals program in the "West Ashley" area of Charleston.

A similar finding in Dorchester County in 1980 led to the community-supported Meals on Wheels of Summerville, Inc. which now serves 80-85 home-bound incapacitated elderly individuals and enlists the assistance of over 300 volunteers.

The Trident Health District now employees a Registered Dietitian for 10% time to consult with home health clients. She states that the many very necessary referrals she is attempting to serve cannot be covered in this allotment of time.

As a health professional, I experience frustration when faced with the multitude of problems an elderly individual can have. In a typical situation we begin discussing a necessary dietary modification to help with a health problem. We discuss the five medications which must be taken at appointed intervals throughthe day to treat her diabetes, arthritis, hypertension, depression and indigestion. Then we discuss the lack of family support, infrequent rides to the grocery and drug stores, the loneliness of cooking for one, the plumbing problems, the faulty stove and how fast the milk sours. I learn that she eats canned soup two to three times a day. Walking or other exercise is out due to the severity of the arthritis, and one never goes out alone because it isn't safe. Oh yes, the dentures don't fit and it hurts to chew. At this point I vow to help younger people to take care of themselves and wish there were more funds available for preventive medicine programs!

Another issue of concern is that of nutritional supplements. Although in some cases limited supplementation is necessary and theraputic, a great deal of unnecessary vitamins, minerals and other preparations are purchased and consumed, with hopes of averting or correcting failing health. A substantial proportion of an elderly person's limited income can be spent on supplements which make a brief trip through the body and on to the city waste water treatment plant. The same money could be spent on good food, electricity, transportation, or even entertainment, the benefits of which are unquestionably more tangible.

Also in hopes of averting or correcting health problems, elderly individuals are highly susceptible to falling prey to misinformation. Misinformation is not confined to nutrition issues, but the prevalence of advertising for useless products touted to take off weight effortlessly, renew energy levels, etc. is astounding! Many citizens believe that truth in advertising laws are obeyed and enforced before any untrue claims could reach them via mass media. Little do they know that most laws apply to labels attached to the products and not to materials referring to the products.

When an elderly individual requests nutritional consultation from his private doctor, the doctor is not likely to go into detail in helping assess and plan an individualized diet. Neither is he likely to set up a consultation with a Registered Dietitian. We hope that in the near future this situation will be changing as third party reimbursement for dietetic services becomes available across the country.

Many members of the Charleston Trident Dietetic Association recognize and respond to the needs of the elderly. We are pleased that the South Carolina Legislature is assessing these needs at this time. We believe that government plays a vital role in serving the ever-increasing proportion of our population who fall into this category.. We are also pleased to work with other organizations who find solutions without calling on government assistance. There are many solutions to the same problem, and as many as can, should help.

Thank you for your attention to this letter and to the attached statement.

Sincerly yours,

Susan Lever

Susan M. Lever, M.S., R.D.
President, CTDA

The needs of the elderly population are unmet in many ways and this population is growing steadily.

The typically declining health and concomitant reduced income characteristic of this population result in special problems for them. The following are problem areas commonly encountered by the elderly.

Transportation-In areas where public transportation is not well-developed, even simple errands are a problem for the elderly, not to mention situations in which transportation is necessary for legal aid, health care, etc..

Household Chores and Home Maintenance - Unskilled care is needed to assist the elderly for many simple day-to-day tasks. Since the elderly often have problems with sight, hearing and general strength, tasks such as yard care, dishwashing and housekeeping in general are often difficult.

Police Protection - The elderly are more vulnerable to break-ins than is the general population.

Housing - Housing available to the elderly on a sliding fee scale is very limited. In the Charleston area, there are 2 facilities offering a total of 250 units to the total elderly population on a sliding fee scale. As of August, 1984, the Charleston County Housing Office reports that a waiting time of 6 to 12 months exists for space available in these facilities and that this waiting time exists continuously. When forced to move, the elderly face a great difficulty in finding affordable housing.

Nutrition Services - Shopping and cooking are critical problems for the elderly. Many elderly people do not eat because the effort necessary for fixing meals seems too great. In the Charleston area, 316 congregate meals and 72 home-delivered meals are served daily. From 1980 census data, it is estimated that this is less than 5% of the population age 60 and above in the Charleston area.

Publications - Publications targeted for the elderly informing them of their rights and of services available are lacking desperately. To a population that is very vulnerable to isolation, such a publication could be extremely valuable.

Societal Attitude - Lastly, one of the biggest problems the elderly face is the feeling of uselessness. Automation, mandatory retirement, and a mobile society have many capable elderly citizens at a loss for a productive outlet. Networking mechanisms are needed for the elderly who want to find worthwhile ways to practice their talents. Without a societal attitude that recognizes the capabilities of the elderly, the elderly population will become more dependent instead of being the contributing force that they can be.

Respectfully submitted,

Eileen Schleelein

Eileen Schleelein, M.S., R.D.
September 11, 1984

TESTIMONY PRESENTED TO
THE STATE OF SOUTH CAROLINA
STUDY COMMITTEE ON AGING
SEPTEMBER 20, 1984

As a professional in the field of Aging for the last seven years, I have known about Alzheimer's Disease and its devastating impact upon the victim and family members. However, since the diagnosis of my father last year, Alzheimer's Disease has become a living nightmare for my entire family.

Although I have not been spared some of life's misfortunes along the way, losing my father day by day, memory by memory, is the most heartbreaking experience of my life. Once known and regarded in the community as a "sharp businessman," clear-headed, a man who enjoyed a good joke with his buddies, Dad is now tortured by his inability to remember how to add, the proper sequence for taking an aspirin, how to drive or even snap a bean. He shuns old friends because he cannot carry on a conversation. He wants to surround himself with the comfort of his children and grandchildren, but their numbers confuse him and he becomes silent and withdrawn.

And Mom... Mom has lost her mate, her friend, her companion. She is full of grief (Alzheimer's Disease is truly the funeral that never ends) and she is bitter that those years they had planned and waited for have been snatched away. And she is worried: How will she care for Dad as his condition worsens? What if she should die first? Will they have sufficient financial resources?

The above is a brief synopsis of the grief, the suffering, and the anxiety that accompanies Alzheimer's Disease -- an irreversible brain disorder whose cause is unknown and for which there is no successful treatment. It is not adequate to look at Alzheimer's Disease as a personal problem, a private trouble. Given the increased incidence of Alzheimer's Disease with advanced age and given the increasing number of the very elderly, our society will experience a dramatic increase in this disease in the next two decades.

At the present, our society is sorely lacking in its ability to respond to the needs of Alzheimer's Disease patients and their families. Some of the resources that must be developed to assist them include the following:

1. Financial Assistance - Neither private insurance nor Medicare will cover the ongoing care required by Alzheimer's Disease patients. (Medicaid will help after all other resources have been depleted.) Yet, in advanced stages, nursing home care or assistance in the home is required. There are also no special tax breaks for caregivers who must give up their jobs outside the home to devote full-time to the patient.

2. Respite and Day Care - As noted by the authors of "The Thirty-Six Hour Day," care for the patient becomes unending and there is never time for the primary caregiver to recoup emotional and physical energies or to take care of necessary business outside the home. Respite and day care services can be a life-saver in that the family members may actually leave their homes for several hours, knowing that care will be provided to their father

or husband. At present, such services are rarely available at all and when they are, they tend to exclude incontinent persons. (We have day care centers for infants who lack bowel/bladder control. Our refusal to accept incontinent adults reflects more our discomfort in confronting the problem than the management problems they create.) Respite and day care may also make it possible to keep the patient at home and thereby avoid the higher cost of institutionalization.

3. Caregiver Support Groups - These groups provide an invaluable resource to caregivers: they relate information about research and the use of drugs for treating and/or controlling aspects of the illness; they provide an outlet for grief, frustration, and anxiety; they give helpful tips on where to get help and what has worked for them. Caregiver support groups, along with respite and day care services, may prevent the primary caregiver from becoming becoming physically and mentally exhausted to the point of another illness in the family.

4. Trained Aging Provider Staff - Personnel -- especially paraprofessionals -- who work with the elderly (nursing and boarding homes, councils on aging, mental health personnel, etc.) have often received little training to deal with demented patients. We must step up our efforts to provide these skills to those who will be on the front-line in caring for such persons.

5. Research - Alzheimer's Disease is the fourth leading cause of death in the United States and affects an estimated 25 million Americans. With projected demographic changes, it is imperative that we devote increased resources to research aimed at identifying the cause(s) and successful treatment.

With no known cause or treatment, Alzheimer's Disease is indeed a time bomb for an aging population such as ours. In the development and recommendation of legislation, I urge this Committee to support any steps -- including the allocation of state dollars -- to assist Alzheimer's Disease victims and their families.

Respectfully submitted,

Sue L. Scally

Sue L. Scally, Ph.D.

SLS/ha

Lexington County Recreation Commission
Aging Program
ROOM 103, COMMUNITY BUILDING
114 NORTH LAKE DRIVE
LEXINGTON, S.C. 29072
TELEPHONE: 359-9961

LINDA C. HALL
COORDINATOR

September 18, 1984

Keller H. Baumgardner
P.O. Box 142
305 Gressette Bldg.
Columbia, S.C. 29202

I am unable to be with you today due to an annual conference of County Council on Aging Directors so I am submitting this written testimony to express some concern that I have regarding our elderly.

I think we are all aware by now of the alarming growth rate of older people in our state who need medical care and community support serviees. A tremendous demand has been placed on home delivered meals, homemaker services and additional support services as a result of older people being dicharged from hospitals still requiring a great deal of community support. For the first time doctors are releasing patients from the hospital only when and if these services can be provided. With full implementation of DRG's (Diagonistic Related Groups) a cost containment factor for hospitals, more and more of the older people will be requiring additional support services and when you add those numbers to the increasing numbers of older people we must have additional money to fund the support systems.

The South Carolina Commission on Aging has introduced a Community Servce Bill in the amount of $2.5 million dollars to fund home delivered meals, homemaker services, adult day care and other essential services.

I urge rge you to support this bill so that we can begin to meet this tremendous need of our elderly population.

I also have concern that of the approximately $800,000 block grant money none was allocated to the elderly except $50,000 to DSS for companion services.

I appreciate the opportunity to express these concerns to you and ask your support in this great challenge.

Sincerely,

Linda Hall

Linda Hall
Coordinator

Route 1, Box 311
Lynchburg, S.C. 29080
September 19, 1984

Blatt Building
P.O. Box 142
Room 305
Sussetee Building
Columbia, S.C. 29202

Dear Sirs:

In response to reading about your hearing we thought we may be able to help us, list as follow is some of our needs.

1- The Center Advisor to get a salary.
2- Transportation to get the Senior Citizens to the Center.
3- part-time jobs for Senior Citizens of the Community.

Yours truly, Elizah Senior Citizen
Mrs. Annie R. Edwards

Senator Rubin, Representative Harris, and other members of the first Legislative Study for the Elderly, thank you for the opportunity to present two or three items of interest on behalf of the elderly citizens of our State.

The first concern I would like to discuss with you is a burial fee for those citizens of our State who expire and have no relatives or assets. There are times when our office receives a call inquiring if there are funds to assist with funeral expenses. There are approximately 12 to 15 cases per year when a nursing home patient or resident of a boarding home expires and there are just no funds for a funeral. The State has provided funds for children for a number of years. I believe elderly citizens should be buried with the same dignity. This request would require approximately $15,000.00. I would suggest we use the same limit per person as we do with children, which is $1,000.00.

The second item I would like to discuss with you is a matter that concerns our nursing home patients and boarding home residents. Especially those who are private pay patients.

The federal certification standards for medicare and medicaid contain a section referred to as the "Patient's Bill of Rights".

The intent of this is to promote the interests and well being of the patients and residents in nursing homes and boarding homes. These residents/patients need assurance through State statute that their fundamental rights are not surrendered on admissions to a long term care facility.

Things that you and I take for granted are not always there for these residents/patients. An example of the rights that I am in reference are: the right to know and make decisions about one's treatment; the rights to privacy, to receive and send mail unopened and to confer with persons or groups of one's choice; the right to be fully informed of one's medical condition unless medically contraindicated; the right to retain and use personal clothing possessions as

space permits. There are several other rights which are listed in the attached sample piece of legislation. More than one half of the states already have this legislation.

I will be willing to work with your staff and the Legislative Counsel to draft the specific legislation for our State. I would suggest that this be placed with the Department of Health and Environmental Control's code section. DHEC would then be able to write regulations based on the statute.

One of the reasons why this is very important, is that the private pay citizens are not protected in the same manner as those who have supplemental government funding. There should be no fiscal impact on the nursing home programs because of the certification standards that are currently in place. I urge your adoption of this proposed legislation.

The last item I would like to discuss also concerns nursing homes. Some of the homes are limiting the number of Medicaid patients they are admitting. In fact, some of the homes are discharging Medicaid patients under questionable conditions. Patient's level of care are being changed, then the home says they do not have a Medicaid bed and discharges the patient to home. Other reports we have received concern changing the level of care of a Medicaid patient then the patient is told no Medicaid bed is available and is billed as private pay, when in fact the patient is still Medicaid eligible. This is a very complicated subject and difficult to explain at this time. I can however, assure you that there is discrimination against many of our Medicaid patients.

When I have a solution, I will contact you to present some legislative relief if that is the proper approach.

Thank you for permitting me to present these thoughts to you.

Submitted by: William V. Bradley
State Ombudsman

Patients Bill of Rights

The right to know and make decisions about one's treatment.

The right to privacy, to receive and send mail unopened and to confer with persons or groups of one's choice.

The right to voice grievances without fear of reprisals.

The right to manage one's own finances or be given a quarterly accounting of the financial transactions made on one's behalf by the home if the patient has delegated that responsibility in writing.

The right not to be transferred except for medical reasons, a patient's own welfare or that of other patients, or for non-payment.

The right to be fully informed of services available and of related charges and fees.

The right to be fully informed of one's medical condition unless medically contraindicated.

The right to freedom from mental and physical abuse, and from chemical and physical restraints (with specified exceptions).

The right to be treated with consideration, respect and dignity.

The right to retain and use personal clothing and possessions as space permits.

The right not to perform services for the home.

The right to marital privacy.

SUGGESTED Legislation

LONG TERM CARE FACILITIES

(Nursing Home Patients' Bill of Rights)

441.600 Definitions for ORS 441.600 to 441.625. As used in ORS 441.600 to 441.625 unless the context requires otherwise:

(1) "Division" means the Health Division of the Department of Human Resources.

(2) "Facility" means a long term care facility as defined in ORS 442.015.

(3) "Legal representative" means attorney at law, person holding a general power of attorney, guardian, conservator or any person appointed by a court to manage the personal or financial affairs of a resident or person or agency legally responsible for the welfare or support of a resident.

(4) "Person" means an individual and every form of organization, whether incorporated or unincorporated, including partnership, corporation, trust, association or administrative agency or political subdivision of this state.

(5) "Resident" means an individual under care in a facility. [1979 c.261 §2]

441.605 Legislative declaration of rights intended for residents. It is the intent of the Legislative Assembly that facilities guarantee at a minimum that each resident has the right to be:

(1) Fully informed of all resident rights and all facility rules governing resident conduct and responsibilities.

(2) Fully informed which services are available and of any additional charges not covered by the daily rates or by Medicare or Medicaid.

(3) Informed by a physician of the medical condition of the resident unless medically contraindicated in the medical record, and given the opportunity to participate in planning medical treatment and to refuse experimental research.

(4) Transferred or discharged only for medical reasons, or for the welfare of the resident or of other residents of the facility, or for nonpayment and to be given reasonable advance notice to insure orderly transfer or discharge.

(5) Encouraged and assisted while in the facility to exercise rights as a citizen, and to voice grievances and suggest changes in policies and services to either staff or outside representatives without fear of restraint, interference, coercion, discrimination or reprisal.

(6) Allowed either to manage personal finances or be given a quarterly report of account if the facility has been delegated in writing to carry out this responsibility.

(7) Free from mental and physical abuse and assured that no chemical or physical restraints will be used except on order of a physician.

(8) Assured that medical and personal records are kept confidential and unless the resident transferred, or examination of the records is required by the third party payment contractor, are not released outside the facility.

(9) Treated with respect and dignity and assured complete privacy during treatment and when receiving personal care.

(10) Assured that the resident will not be required to perform services for the facility that are not for therapeutic purposes as identified in the plan of care for the resident.

(11) Allowed to associate and communicate privately with persons of the resident's choice and send and receive personal mail unopened unless medically contraindicated by the attending physician in the medical record of the resident.

(12) Allowed to participate in activities of social, religious and community groups at the discretion of the resident unless medically contraindicated.

(13) Able to keep and use personal clothing and possessions as space permits unless to

do so infringes on other residents' rights and unless medically contraindicated.

(14) Provided, if married, with privacy for visits by the resident's spouse. If both spouses are residents in the facility, they are permitted to share a room. [1979 c.261 §4]

441.610 Nursing home patients' bill of rights; adoption; standards. (1) Within 120 days after June 19, 1979, the division shall adopt a nursing home patients' bill of rights consistent with the principles set forth in ORS 441.605. The rules shall be applicable to all residents and as far as practicable shall conform to any federal nursing home patients' bill of rights.

(2) The division shall periodically review the rules to assure that they meet the principles set forth in ORS 441.605 and that they are in conformity with federal standards but in no case shall the rules be less protective than required by ORS 441.605.

(3) The division shall be guided by federal interpretative standards in its enforcement of the nursing home patients' bill of rights. [1979 c.261 §5]

441.615 Powers and responsibilities of Health Division. In the administration of ORS 441.600 to 441.625, 441.710 and 441.715, the division shall have the following powers and responsibilities:

(1) To inspect any facility and the records of any facility to insure compliance with ORS 441.600 to 441.625, 441.710 and 441.715.

(2) To adopt rules in accordance with ORS 183.310 to 183.500, including but not limited to procedures for investigations and administrative hearings.

(3) To file complaints and initiate proceedings for the enforcement of ORS 441.600 to 441.625, 441.710 and 441.715 or of rules adopted under ORS 441.600 to 441.625, 441.710 and 441.715.

(4) To issue subpenas. [1979 c.261 §3]

441.620 Disclosure of business information required. Each facility shall disclose to the resident in writing its legal name and business address, and the name and business address of the administrator of the facility, at the time of admission of a resident. Information required to be disclosed by this section shall be kept current. [1979 c.261 §6]

441.625 Retaliation against resident exercising rights prohibited. (1) No facility, or any person subject to the supervision, direction or control of a facility, shall retaliate against a resident by increasing charges, decreasing services, rights or privileges, or threatening to increase charges or decrease services, rights or privileges, by taking or threatening any action to coerce or compel the resident to leave the facility, or by abusing or threatening to harass or to abuse a resident in any manner, after the resident or the resident's legal representative has engaged in exercising rights given under ORS 441.605 or under rules of the division under ORS 441.610. [1979 c.261 §7]